89 29486

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed ... filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN J. HEALY | | | | | 2. DATE OF DEATH (Month, Day, Year): 10 29 89 | 3. TIME OF DEATH: 5:00 P M |
| 4. SOCIAL SECURITY NUMBER: 220-40-8140 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 45 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 04 08 44 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3408 BELAIR ROAD | | 10f. ZIP CODE: 21213 | | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PAINTER | 16b. KIND OF BUSINESS/INDUSTRY: | | | | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN J. HEALY, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELLA BECK | | | | |
| 19a. INFORMANT'S NAME (Type/Print): LORETTA RATHBUN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3408 BELAIR ROAD, BALTO., MD. 21213 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MOUNT CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz Jr | 22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211 | | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

25. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Freeman MD
29c. LICENSE NUMBER: 037065
29d. DATE SIGNED (Month, Day, Year): ▶ Oct 30, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD W. FREEMAN MD, 4940 EASTERN AVE. Balto 21224

31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RALPH E. JOHNSON / Ralph Johnson | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 89 | 3. TIME OF DEATH: 9:05 A M |
| 4. SOCIAL SECURITY NUMBER: 262-12-5414A | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/29/08 | 8. BIRTHPLACE (State or Foreign Country): MINN |
| 9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH HOSPITAL, INC | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALT. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6225 YORK RD APT NORTH 209 | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: US. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Radio Tech. | 16b. KIND OF BUSINESS/INDUSTRY: Service | |
| 17. FATHER'S NAME (First, Middle, Last): John L. Johnson | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Selma Shipp | | |
| 19a. INFORMANT'S NAME (Type/Print): Nancy H. Johnson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6225 York Rd.Apt. N209 Baltimore,Md. 21212 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Pk. | 20c. LOCATION — City or Town, State: Baltimore,Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: C. Sherman Denny, Jr. | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | 12 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

end stage heart failure
valvular heart disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A. Trivelina MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 10/26/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): F. Trivelina MD | | |
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

ITEM:23pt1, and DELETE part 2
per ME G-662 4-25-90 cm

89 29488

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Frank | J. | Jowanowith | 10-27-89 | 6:45AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-30-7474 | 1 [X] M 2 [ ] F | 52 YRS. | | | 10/28/1936 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 26 E. Heath Street | Baltimore City | -------- |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | --------- | Balto.City,Md. | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 26 E.Heath St. | 21230 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8th.Grade | ------ | Ret.Laborer | Carpenter Work |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Frank ----- Jowanowitch | Margaret ----- Carnes |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Judith A.Jowanowitch | 3327 Birchwood Blvd,Pittsburg,Pa.15217 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Crestlawn Mem.Gardens | Howard Co.Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Balto.Md.21230 McCully Funeral Home,130 E.Fort Ave. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease and acute | |
| DUE TO (OR AS A CONSEQUENCE OF): | alcohol intoxication | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XXX YES 2 [ ] NO | XXX YES 2 [ ] NO |
| PARTIAL | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home XXX Residence 8 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| XXX 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 10-27-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Mario F. Golle, Jr.,MD | 111 Penn Street,Baltimore,MD 21201 VC |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29498

OCT 31 1989

89 29489

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jones, Herman | | | 2. DATE OF DEATH (Month, Day, Year): 10 29 89 | 3. TIME OF DEATH: 7 35 PM |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 05/02/53 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Frances Scott Key Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: MD | | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| 10e. STREET AND NUMBER: 3412 Dupont Avenue | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. | | |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES: 11-3-72 - 11-5-74 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | | |
| 17. FATHER'S NAME (First, Middle, Last): Leon Jones Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Isabella Walker | | | |
| 19a. INFORMANT'S NAME (Type/Print): Leon Jones JR | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8307 Tinsley Road | | | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest VA Cemetery | 20c. LOCATION — City or Town, State: Balto Co. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dan Cowle | 22. NAME AND ADDRESS OF FACILITY: 1712-14 W. North Ave | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. resp arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Neoplasm in brain / lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | 25. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |
|---|---|

| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Hal A. Glotfelty, MD | D33550 | ▶ 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson Randall |

DHMH-18 Rev 1/89

89 29/89

89 29490

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

6

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): STEPHEN (STEVEN) N. JOHNSON | | | | 2. DATE OF DEATH (Month, Day, Year): 10 - 28 - 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 216-50-0592 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 39 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12-31-49 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 2302 E. Biddle Street | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: none |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2302 E. Biddle Street | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Negroid |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled | 16b. KIND OF BUSINESS/INDUSTRY: none | |
| 17. FATHER'S NAME (First, Middle, Last): Sylvester Johnson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline Strickland | |
| 19a. INFORMANT'S NAME (Type/Print): Pauline Wiggins | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2302 E. Biddle St. Baltimore, Md. 21213 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem/Owingsmills, Md. | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin B. Scruggs, Sr. | | 22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Laryngeal Carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy D. Nichols MD | 29c. LICENSE NUMBER: D37836 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 22 S. Greene St., Baltimore, MD 21201 University Hospital | | |
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2/90

OCT 31 1989

89 29491

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Johnson, Sarah
2. DATE OF DEATH (Month, Day, Year): 10 29 89
3. TIME OF DEATH: 7:45 AM
4. SOCIAL SECURITY NUMBER: 217-34-4727
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-14-10
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3616 Lucille Ave
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5 +)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Thomas Goode
18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Crump
19a. INFORMANT'S NAME (Type/Print): Peggy Fields
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3616 Lucille Ave Balto, Md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Mem Park
20c. LOCATION — City or Town, State: Arbutus, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March F. H. West 4300 Wabash Ave

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis — 10d
DUE TO (OR AS A CONSEQUENCE OF): b. Decubitus Ulcers
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): c. Rem CVA
DUE TO (OR AS A CONSEQUENCE OF): d. peripheral vascular disease

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ethan Dubi MD
29c. LICENSE NUMBER: 035782
29d. DATE SIGNED (Month, Day, Year): 10/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ethan Dubin Liberty Medical Center, Baltimore Md
31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

10

89 29492

Item:1 per FH G-657
11-14-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Mark | Thomas | Koppleman ~~Koppelman~~ | Oct. 29, 1989 | 2:40PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216.78.4039 | 1 [X] M 2 [ ] F | 29 YRS. | | | Aug. 17, 1960 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| University Hospital | Baltimore City | Baltimore City |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 7839 Americana Circle, Apt. 101 | 21061 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | None | Sheet Metal Work | Local Union #100 |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Jerome C. Koppleman, Jr. | June E. Thomas |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. June E. Tester | E. 40 Craig Drive, Jessup, Maryland 20794 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Gambrills Church of God Cemetery | Gambrills, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| R George Hopkins | #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Craniocerebral trauma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX 1 YES 2 [ ] NO | XX 1 YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX 1 YES 2 [ ] NO | HOSPITAL: XXX 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 10-25-89 | 3:00AM M | 1 [ ] YES 2 XX NO | PEDESTRIAN CARRIED BY AUTOMOBILE WITH FALL ~~Pedestrian struck by auto~~ |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Road -home | 7839 Americana Drive, Southdale, Anne Arundel County, Maryland |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 10-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-t6 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ITEM:28f per ME G-664 6-28-90
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29493

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ARTHUR | L | KENDALL | 10 / 24 / 89 | 625 PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220 24 5907 | 1 XX M 2 ☐ F | 59 YRS. | | | Dec. 10, 1929 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1 ☐ YES 2 XX NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 303 Broadway Ave. | 21061 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 X NO | 1 ☐ YES 2 X NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Chemical Operator | Chemical Plant |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Wright Kendall | Hilda Eckhardt |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Patricia A. Kendall | 303 Broadway Ave., Glen Burnie, MD 21061 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Western Cemetery | Baltimore, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Stephen D. Schumann | McCully Funeral Home of Pasadena<br>3204 Mountain Rd., Pasadena, Maryland 21122 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiogenic Shock

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. Acute renal failure
DUE TO (OR AS A CONSEQUENCE OF):
d. Ventricular Tachycardia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D36256 | ▶ 10/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JORGE M. RAMIREZ, M.D. 7845 OAKWOOD ROAD, #205 GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29494

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET M. KOCH
2. DATE OF DEATH — MONTH: 10 DAY: 26 YEAR: 89
3. TIME OF DEATH: 6:25 A M
4. SOCIAL SECURITY NUMBER: 217 01 9286
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Dec. 6, 1917
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ---------
10c. CITY, TOWN OR LOCATION: Balto.City,Md.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1736 S.Hanover St.
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th.Grade — College (1-4 or 5+): --------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): William J. Wengert
18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie ---- Boston

19a. INFORMANT'S NAME (Type/Print): Mrs.June Watts
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1715 Byrd St.Balto.Md.21230

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park
20c. LOCATION — City or Town, State: Glen Burnie, Md. A.A.Co.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Daniel A. Hayes
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home, 130 E. Fort Ave. Balto.Md.21230

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | (R) INTRACEREBRAL HEMORRHAGE | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | FRACTURE OF HIP | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | FALL AT HOME | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — APPROVAL
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ [illegible] 2 ☑ Accident 3 ☐ [illegible] 4 ☐ [illegible] 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 10-18-89
28b. TIME OF INJURY: 3:00P M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: Subject fell at home
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1736 S. Hanover Street, Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] House Staff
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 10/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HARBOR HOSPITAL CENTER, 3001 S. HANOVER ST. BALTIMORE, MD 21230

31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

89 29495

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| EVELYN | AMELIA | LAW | Oct. 28 1989 | 655 AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217.05.6619 | 1 ☐ M 2 ☒ F | 75 YRS. | | | Jan. 9 1914 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 7635 Ninth Court | 21061 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | None | Checker (Ret) | Departmernt Store |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Henry B. Schulz | Gertrude Ruby |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carl B. Law | Same as #10 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Cedar Hill Cemetery | Brooklyn, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ R. George Hopkins | #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md. |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 26c. INJURY AT WORK? | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D18508 | ▶ 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. CHARLES WU, M.D. 7845 OAKWOOD ROAD, #204 GLEN BURNIE, MD 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Kemmler |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29496

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

4

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Carl | Barron | Lee | 10 / 27 / 89 | 2:58 A. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-92-9097 | 1 X M 2 ☐ F | 14 YRS. | | | 06-09-75 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| University Hospital - STU | Baltimore | none |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | none | Baltimore City | 1 X YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1034 Cameron Road | 21212 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 X YES 2 ☐ NO | 1 XX YES 2 ☐ NO Specify: | Specify: Negroid |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8th grade | none | Student | Middle School |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Arthur Lee | Elaine Bowie |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Elaine Lee | 5300 Leith Road Apt. C. Balto.Md. 21239 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Arbutus Memorial Park | Balto. Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Calvin B. Scruggs Sr. | Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto.Md. 21213 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple Injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 XX YES 2 ☐ NO | 1 X YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 XX YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 10-27-89 | 1:44A M | 1 ☐ YES 2 XX NO | driver of auto lost control, overturned and was ejected |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| highway | Rt.27 - south of Baker Rd.,Carroll Co., Md. |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle Jr. M.D. | OCME | 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Mario F. Golle, Jr., M.D. 111 Penn St., Balto., Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29497

Items 20b&20c 11-2-89 Film G657 W.H. Per F/H Items:23pt1&2 per ME G-657 11-6-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Archie | Melvin | Lynch | 10 / 28 / 89 | 7:38 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-54-3277 | 1 [X] M 2 [ ] F | 38 YRS. | | | 5/01/51 | LAWRENCEVILLE, VA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Washington County Hospital | Hagerstown | Washington |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 921 N. STRICKER STREET | 21217 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 9th | | LABORER | MD STATE PENITENTIARY |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| VANDAS LEE LYNCH, SR. | BETTY WASHINGTON |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| VANDAS L. LYNCH | 921 N. STRICKER STREET/BALTIMORE, MD 21217 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE (Name) | 20c. LOCATION (City, State) |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | ~~BALTIMORE CEMETERY~~ Western Star Cemetery | ~~BALTIMORE, MD~~ Catonsville, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Vanessa Davis | WM. C. MARCH F/H 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hemoptysis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Erosion of pulmonary vein by Adenocarcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Frank Peretti MD | OCME | 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Frank J. Peretti, M.D. - Assistant 111 Penn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

Received 83 Jan 31

89 29498

Item:9a per FH G-657
11-28-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERTA G LEE | | | | 2. DATE OF DEATH: MONTH 10 DAY 27 YEAR 1989 | 3. TIME OF DEATH: 4:14 PM |
| 4. SOCIAL SECURITY NUMBER: 214-16-8968 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/31/23 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): ~~CHURCH HOSPITAL~~ University Maryland | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH | |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10a. STREET AND NUMBER: 3923 REXMERE ROAD | | 10f. ZIP CODE: 21218 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM MILBOURNE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): VICTORIA HALL | | | |
| 19a. INFORMANT'S NAME (Type/Print): MELVIN LEE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3923 REXMERE ROAD/BALTIMORE, MD 21218 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PARK | | 20c. LOCATION — City or Town, State: RANDALLSTOWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. END STAGE RENAL DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DIABETES | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Frank Procaccino MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANK PROCACCINO 22 S. GREENE St. BALTIMORE Md. 21201

31. DATE FILED (Month, Day, Year): OCT 31 1989

32. REGISTRAR'S SIGNATURE: Julia Hudson

DHMH-16 Rev 1/89

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2ep90

| | | | |
|---|---|---|---|
| 214-16-8968 | X | 66 | 10\31\23 MD |
| CHURCH HOSPITAL | | BALTIMORE | |
| MD | | BALTIMORE | X |
| 3923 REXMERE ROAD | | 21218 | USA |
| X | X | X | BLACK |
| | HOMEMAKER | | DOMESTIC |
| WILLIAM MILBOURNE | | VICTORIA | HALL |
| MELVIN LEE | | 3923 REXMERE ROAD\BALTIMORE, MD 21218 | |
| X | KING MEMORIAL PARK | | RANDALLSTOWN, MD |
| WM. C. MARCH F\H 1101 E. NORTH AVENUE | | | |

Thomas Davis

89 29499

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERTHA MIK — BARTHA MIK
2. DATE OF DEATH (Month, Day, Year): 10-25-89
3. TIME OF DEATH: 8:45 pm M
4. SOCIAL SECURITY NUMBER: 218-05-9045
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 78 YRS. — IF UNDER 1 YEAR: MONTHS 2 DAYS 5 — IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-30-11
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): JOHN L. DEATON — JOHN L. DEATON
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND — MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE — BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: FOREST HAVEN NSG. HOME 315 INGLESIDE AVE. BALT., MD. 21228
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? USA — USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE — WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): TO 7th GRADE — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FACTORY WORKER — FACTORY WORKER
16b. KIND OF BUSINESS/INDUSTRY: FACTORIES — FACTORY
17. FATHER'S NAME (First, Middle, Last): ANDREW MIK — ANDREW MIK
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY PIETA — MARY PIETA
19a. INFORMANT'S NAME (Type/Print): MRS. VICTORIA RASINSKI
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6712 RIVER DRIVE ROAD 21219
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): st. STANISLAUS CEMETERY
20c. LOCATION — City or Town, State: BALTO. MD 21224
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski
22. NAME AND ADDRESS OF FACILITY: Kaczorowski Funeral home 2525 FLEET ST. BALTO. MD. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. UroSepsis | 2 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. foley catheter for incontinence | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. dementia | 15 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Decubitus ulcer, gastrostomy tube, schizophrenia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy J. Keary, M.D.
29c. LICENSE NUMBER: D 37458
29d. DATE SIGNED (Month, Day, Year): ▶ 10/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Judith Davidson Pendell

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29500

1 - FOR STATE REGISTRAR DAISY E. MORRIS

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Daisy English Morris | | | 2. DATE OF DEATH (Month, Day, Year): 10/26/89 | 3. TIME OF DEATH: 1954 M |
| 4. SOCIAL SECURITY NUMBER: 212-24-4121 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10/25/26 | 8. BIRTHPLACE (State or Foreign Country): MD. |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK | 9c. COUNTY OF DEATH: FREDERICK |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: DAMASCUS | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 25111 OAK DRIVE | | 10f. ZIP CODE: 20872 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: HOME | |
| 17. FATHER'S NAME (First, Middle, Last): EARNEST FRALEY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DAISY ALLNUTT | |
| 19a. INFORMANT'S NAME (Type/Print): PAUL MORRIS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS #10 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LAYTONSVILLE CEMETERY | 20c. LOCATION — City or Town, State: LAYTONSVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Muriel H. Barber | 22. NAME AND ADDRESS OF FACILITY: MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. D Electrical Mechanical Dissociation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myocardial infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary artery disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: cerebral vascular accident

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John A. Vitarello MD | 29c. LICENSE NUMBER: D27544 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN A. VITARELLO FREDERICK, MD. 21701

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 10/27/1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29501

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Josephine McNulty (Josephine McNulty) | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 29 / 89 | 3. TIME OF DEATH: 6 45 AM |
| 4. SOCIAL SECURITY NUMBER: 217-14-5036 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 93 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9/1/96 | 8. BIRTHPLACE (State or Foreign Country): Balto. Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Manor Care Rossville - N.H | | 9b. CITY, TOWN OR LOCATION OF DEATH: 6600 Ridge RD, Balto. | | 9c. COUNTY OF DEATH: Balto. Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Rossville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6600 Ridge Road | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th GRade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): John A. Miller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FRances Rice | |
| 19a. INFORMANT'S NAME (Type/Print): Elva M. Fry | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 435 Meadow Road Baltimore, Md.-21206 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy | | 22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. | 6415 Belair Road Balto. Md. 21206 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute CHF | |
| DUE TO (OR AS A CONSEQUENCE OF): | Arteriosclerotic Cardiovascular | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Md. | 29c. LICENSE NUMBER: D08358 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Manor Care Rossville | | |
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Item#4 Film#g657 11/07/89 da per F.H. 89

89 29502

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS JOSEPH NADARZYNSKI / THOMAS NADARZYNSKI | | | 2. DATE OF DEATH (Month, Day, Year): 10 24 1989 | 3. TIME OF DEATH: 12.39 PM |
| 216-03-7267-A / ~~215-22-6349~~ | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 12/21/1911 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: n/a | | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | n/a | Baltimore | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3602 Seventh Street, | 21225 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 5 | | Retired Machinist | Westinghouse Corp. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Walter Nadarzynski | Frances ----- |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Ressie V. Nadarzynski | 3602 Seventh St., Baltimore, Maryland 21225 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Buriet 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Loudon Park Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Kevin E. Ecker | McCully Funeral Home of Brooklyn<br>237 E. Patapsco Ave., Balto., Md. 21225 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS Multi system failure. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. G. I. Bleeding | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Renal Insufficiency | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Respiratory failure | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA<br>OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | N A | N A M | N A 1 [ ] YES 2 [ ] NO | N A |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| N A | N A |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Intern (Medicine) | | ▶ 10/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SYED M. A. RIAZ 1301 LINCOLN WOODS DR. BALT. MD 21228

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29503

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles E NELSON | | | 2. DATE OF DEATH (Month, Day, Year): October 30, 1989 | 3. TIME OF DEATH: 12:15 AM |
| 4. SOCIAL SECURITY NUMBER: 215-10-5655 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8-12-08 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH: Baltimore County |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Balto. | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5432 Bucknell Rd. | | 10f. ZIP CODE: 21206 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Yeast Tester | | 16b. KIND OF BUSINESS/INDUSTRY: Fed. Yeast |
| 17. FATHER'S NAME (First, Middle, Last): George E. Nelson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna | | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth F. Marshall | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5432 Bucknell Rd. Balto., Md. 21206 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | | 20c. LOCATION — City or Town, State: BAlto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: John C. Miller Inc. 6415 Belair Rd. Balto., Md. 21206 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Urosepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Dehydration

DUE TO (OR AS A CONSEQUENCE OF):

c. Cardiac arrythmias

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Adolph M. Wychulis M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Adolph M. Wychulis, M.D. 9000 Franklin Square Drive 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29504

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Stella STELLA MAY POOLE Poole
2. DATE OF DEATH — MONTH: 10 DAY: 30 YEAR: 89
3. TIME OF DEATH: 11~~88~~ P M
4. SOCIAL SECURITY NUMBER: 194 18 4715
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/29/03
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital of Baltimore
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Balto. City.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: N/A
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 713 Argonne Drive
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Grady
18. MOTHER'S NAME (First, Middle, Maiden Surname): Halderman
19a. INFORMANT'S NAME (Type/Print): Louis F. Poole
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 713 Argonne Dr. Baltimore, Maryland 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis S. Xenakis
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebrovascular Accident | 10 min. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Irving Weinberg MD PhD, Resident
29c. LICENSE NUMBER: S-H- 9312
29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Irving Weinberg MD, PhD, Dept of Medicine, Sinai Hosp of Balto.
31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kamdar

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DHMH-18 Rev 1/89

89 29505

1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNEST LUTHER PRINCE
2. DATE OF DEATH (Month, Day, Year): 10 25 89
3. TIME OF DEATH: 110 AM
4. SOCIAL SECURITY NUMBER: 234 26 8451
5. SEX: XX M 2 ☐ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 12, 1910
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Pasadena
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 858 Swift Rd.
10f. ZIP CODE: 21122
10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pipefitter
16b. KIND OF BUSINESS/INDUSTRY: Construction

17. FATHER'S NAME (First, Middle, Last): John Luther Prince
16. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Brown

19a. INFORMANT'S NAME (Type/Print): Murrel G. Prince
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 858 Swift Rd., Pasadena, Maryland 21122

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park
20c. LOCATION — City or Town, State: Glen Burnie, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen D. Schumann
22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Pasadena, 3204 Mountain Rd., Pasadena, MD 21122

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ASPIRATION PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):
b. GASTROINTESTINAL BLEEDING
DUE TO (OR AS A CONSEQUENCE OF):
c. ESOPHAGEAL and GASTRIC ULCERS
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COMPLEX Ventricular ARRHYTHMIAS, URINARY INFECTION, PROSTATIC CARCINOMA WITH BONE METASTASIS, RENAL INSUFICIENCY, Alzheimer's DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ana Maria Martinez MD
29c. LICENSE NUMBER: D37229
29d. DATE SIGNED (Month, Day, Year): ▶ 10/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANA M. MARTINEZ, M.D. 2932-A MOUNTAIN ROAD PASADENA, MARYLAND 21122

31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29506

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emma POCHE
2. DATE OF DEATH (Month, Day, Year): 10 30 1989
3. TIME OF DEATH: 8:35 A M
4. SOCIAL SECURITY NUMBER: 212-40-6483
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 11,1919
8. BIRTHPLACE (State or Foreign Country): MAryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Rossville
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: BAltimore
10c. CITY, TOWN OR LOCATION: Essex
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 108 Bladen Road
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Albert Hanzlik
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Martin
19a. INFORMANT'S NAME (Type/Print): Elaine Maurer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 Bladen Road Baltimore MAryland 21221
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery
20c. LOCATION — City or Town, State: Baltimore MAryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly
22. NAME AND ADDRESS OF FACILITY: ConnellyFuneral Home 300MAceAve. 21221

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Peripheral Vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Tonya L Gosha MD
29c. LICENSE NUMBER: NA
29d. DATE SIGNED (Month, Day, Year): October 30, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Tonya L. Gosha, MD 9000 Franklin Square Drive Baltimore, Maryland
31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall 21237

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29506

Item 1 11-1-89 Film G657 W.H. Per F/H

89 29507

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Ruth | AKA Ruth Rozella Parks<br>Rosella | Parks | Octo 29, 1989 | 11:00A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-28-2812 | 1 ☐ M 2 ☒ F | 82 YRS. | | | Sept. 15 1907 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 18026 Bunker Hill Road | Parkton | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Parkton | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 18026 Bunker Hill Road | 21120 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO<br>IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Housewife | Homemaking |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Samuel Redman | Alice Young |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Howard E. Parks, Jr. | 18026 Bunker Hill Road, Parkton, Md. 21120 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mays Chapel United Meth. Ch. Cem. | Timonium, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Martin D. Lawson | Lemmon-Mitchell-Wiedefeld<br>10 W. Padonia Rd., Timonium, Md. 21093 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASCVD<br>DUE TO (OR AS A CONSEQUENCE OF): | 2+yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b.<br>DUE TO (OR AS A CONSEQUENCE OF): | |
| | c.<br>DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Upper Respiratory Infection

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles F. O'Donnell MD | D-09383 | ▶ 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Charles F. O'Donnell MD - 7501 York Rd - Towson Md 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2507

OCT 31 1989

89 29508

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH J. PERRONE — JOSEPH J. PERRONE
2. DATE OF DEATH (Month, Day, Year): 10 28 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-18-2030
5. SEX: 1 X M 2 ☐ F
6. AGE (If yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-27-02
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): ST. JOSEPH HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Lutherville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 39 Thornhill Road
10f. ZIP CODE: 21093
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner
16b. KIND OF BUSINESS/INDUSTRY: Van's Pet Supply
17. FATHER'S NAME (First, Middle, Last): Joseph Perrone
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Dosicidas
19a. INFORMANT'S NAME (Type/Print): Helen H. Perrone
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same As #10
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 10-31-89
20c. LOCATION — City or Town, State: Parkville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randall C. Shipley Sr.
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Recurrent congestive heart failure
DUE TO (OR AS A CONSEQUENCE OF):
b. status post myocardial infarction
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
d. Arteriosclerosis

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Cardiac arrhythmia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ✓ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ✓ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. Zalduondo MD
29c. LICENSE NUMBER: D29306
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALFONSO P. ZALDUONDO 7620 York Rd MD 21204
31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29509

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH MARY RIELLY | | | | 2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89 | 3. TIME OF DEATH: 10:15A M |
| 4. SOCIAL SECURITY NUMBER: 138-28-1350 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-12-05 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): Meridian Long Green | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: N/A |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2300 Dulaney Valley Road | | 10f. ZIP CODE: 21204 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ ND IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): Richard Savage | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna E. Grotz | | | |
| 19a. INFORMANT'S NAME (Type/Print): Sr. Therese Marie Dougherty | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4701 N. Charles St. Balto. Md. 21210 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New St. Mary's Cemetery | | 20c. LOCATION — City or Town, State: Bellemawr, New Jersey | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dennis S. Xenakis / Dennis S. Xenakis | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home 6500 York Road 21212 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebro Vascular Accident

DUE TO (OR AS A CONSEDUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (DR AS A CONSEDUENCE OF):

c. DUE TO (DR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Sperling MD | D28987 | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CARL SPERLING MD 302 E. 33RD ST. BALTO. MD 21218

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29509

OCT 31 1989

89 29510

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EARL SIMMONS | | | | 2. DATE OF DEATH (Month / Day / Year): OCT 26 89 | 3. TIME OF DEATH: 9:02 AM |
| 4. SOCIAL SECURITY NUMBER: 225 46 8978 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 51 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-23-38 | 8. BIRTHPLACE (State or Foreign Country): Va. |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. | | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Balto. | 10c. CITY, TOWN OR LOCATION: Turners Station | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 307 N. Avondale Rd. | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: / | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY: Trucking |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Earl J. Simmons | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Purdy |
| 19a. INFORMANT'S NAME (Type/Print): Carlisa Young | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 727 N. Avondale Rd. Balto., Md. 21222 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge | 20c. LOCATION — City or Town, State: Balto., Md/ |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton | 22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons 1701 Laurens St. Balto., Md. 21217 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO PULMONARY FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. METASTATIC ESOPHAGEAL CANCER | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Michael D. Pressel, MD | 29c. LICENSE NUMBER: [illegible] | 29d. DATE SIGNED (Month, Day, Year): 10/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL D. PRESSEL, MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

8

89 29511

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| KENNETH | CLARK | SHERMAN | October 27, 1989 | 12 NOON M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 049.10.7307 | 1 [X] M 2 [ ] F | 83 YRS. | | | Sept.23, 1906 | Connecticut |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Meridian Nursing Center 24 Truckhouse Road | Severna Park | Anne Arundel |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Glen Burnie | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 725 Delmar Avenue | 21061 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th. | 4 years | Design Engineer | Sherman Pinsetters, Inc. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Clark Alexander Sherman | Elizabeth Greenleif |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. James W. McCartney | Rt. 219 N., P.O. Box 206, Oakland, Maryland 21550 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Glen Haven Memorail Park | Glen Burnie, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ R. George Hopkins | #1 Second Ave. S.W. Singleton Funeral Home, Glen Burnie, Md./21061 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ISCHEMIC HEART DISEASE | 10-12 wks. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HODGKIN'S LYMPHOMA

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Attending MD | D 21776 | ▶ 10/26/89. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. S. P. Mundra 102 N. Crain Hwy. Glen Burnie, Md. 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29512

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James Hull | | | 2. DATE OF DEATH: MONTH 10 DAY 27 YEAR 89 | 3. TIME OF DEATH: AM 9:07 M |
| 4. SOCIAL SECURITY NUMBER: 212-12-7314 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10 19 06 | 8. BIRTHPLACE (State or Foreign Country): md |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Unkn | 10f. ZIP CODE: Unkn | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced N/A | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES N/A | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Unkn | 16b. KIND OF BUSINESS/INDUSTRY: Unkn | |
| 17. FATHER'S NAME (First, Middle, Last): Unkn | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unkn | | |
| 19a. INFORMANT'S NAME (Type/Print): Gail Dandensky | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1114 Cathedral St. Balto. Md 21202 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Zion | 20c. LOCATION — City or Town, State: Baltimore md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary M. Wallace | 22. NAME AND ADDRESS OF FACILITY: Wallace Funeral Service 3405 W. Franklin St. Balto. Md | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Schizophrenia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO (HEAD ONLY) | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn St., Balto., Md. 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall |

DHMH-16 Rev 1/89

Edna Spencer

89 29513

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDNA MAE SPENCER | | | 2. DATE OF DEATH (Month, Day, Year): 10/27/1989 | 3. TIME OF DEATH: 3:00 A. M |
| 4. SOCIAL SECURITY NUMBER: 216-10-6454 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/27/1919 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Seton Hill Manor Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: n/a |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6638 Whitmore Court, | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Housewife | |
| 17. FATHER'S NAME (First, Middle, Last): Harry Reddish | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha --- Reddish | |
| 19a. INFORMANT'S NAME (Type/Print): Ms. Bonnie L. Owens | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3148 Cardinal Drive, Westminster, Md. 21157 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, INC. | 20c. LOCATION — City or Town, State: Catonsville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker | | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral Home of Brooklyn 237 E. PAtapsco Ave., Balto., Md. 21225 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only ona cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | 4 hr. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(1) Stroke
(2) CHF 2° to ASCVD
(3) Severe Dementia; w/ gastrostomy tube

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jaime Punzalan MD | | 29c. LICENSE NUMBER: D0124 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAIME PUNZALAN - 5214 Harford Rd. Balto. Md. | | | |
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29513

RELEASED NON-MED PER MR LAWYER/DR GOLLE

89 29514

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH G. SVOBODA | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 27, 1989 | 3. TIME OF DEATH: 12:15 A M |
| 4. SOCIAL SECURITY NUMBER: 214-03-2921 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-10-08 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2036 GOUGH STREET | | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 YEARS; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DRIVER | 16b. KIND OF BUSINESS/INDUSTRY: TEAMSTER | |
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH F. SVOBODA | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN HUPKA | |
| 19a. INFORMANT'S NAME (Type/Print): MRS LUCILLE SVOBODA | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2036 GOUGH STREET BALTO. MD. 21231 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY ROSARY CEMETERY | 20c. LOCATION — City or Town, State: BALTO. CO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski | 22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. 21224 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | SQUAMOUS cell lung cancer | 5 mos |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. | H/O cardiac Arrythmias; | 10 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD (MEDICAL INTERN) | 29c. LICENSE NUMBER: E9989 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RACHEL W. HUMPHREY, MD JOHNS HOPKINS HOSPITAL BALTIMORE MD 21205 | | |
| 31. DATE FILED (Month, Day, Year): 00131 1989 | 32. REGISTRAR'S SIGNATURE: Jeanne Davidson-Randall | |

DHMH-16 Rev 1/99

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 2951

89 29515

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helen C. SMITH | | 2. DATE OF DEATH (Month, Day, Year): October 26, 1989 | 3. TIME OF DEATH: 2:10 A M |
| 4. SOCIAL SECURITY NUMBER: 212-28-6607 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-28-04 |
| 8. BIRTHPLACE (State or Foreign Country): Dickson City, Pa. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3008 Iona Terrace | 10f. ZIP CODE: 21214 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Usczewski | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Kulawski | | |
| 19a. INFORMANT'S NAME (Type/Print): Dorothy Cochran | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3004 Bellechase Road Fallston, Md.-21047 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Belair Memorial Gardens | 20c. LOCATION — City or Town, State: BElair, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph B Beil Jr. | 22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 Belair Road Baltimore, Md.-21206 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Overwhelming Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Maria C Sam MD. | | ▶ October 26, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Maria C. Sam, M.D. 9000 Franklin Square Drive, Baltimore, MD 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29516

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|
| KATHRYN SCHUBERT | | 10 / 26 / 89 | 11:45 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 071 24 9640 | 1 ☐ M 2 ☒ F | 78 YRS. | | | 11 06 10 | New York |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| GREATER BALTIMORE MEDICAL CENTER | TOWSON | BALTIMORE |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | BALTIMORE | PARKVILLE | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1805 ABERDEEN RD | 21234 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Office worker | Metropolitan Life |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JOHN FORGARTY | KATHRYN OKEEFE |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Carol Ann Reda | 2415 Cider Mill Rd., Balto., Md. 21234 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | St.John's Cemetery 10/31/89 | Middle Village, N.Y. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO PULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MI | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ayman Akkad MD | — | ▶ 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

AYMAN AKKAD, M.D. 6701 N CHARLES ST BALTIMORE MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Jeka Davidson-Randall |

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29516

OCT 31 1989

89 29517

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Gina Marie Stevens (Fitch) | | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 19 / 89 | 3. TIME OF DEATH: 6:30 pm M |
| 4. SOCIAL SECURITY NUMBER: None | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): YRS. | IF UNDER 1 YEAR: MONTHS 3 / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-17-89 | 8. BIRTHPLACE (State or Foreign Country): Salisbury, Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital of Baltimore | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Wicomico | 10c. CITY, TOWN OR LOCATION: Salisbury, Maryland | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Route 4 Johnson Rd. Eastwood Village #14 | | 10f. ZIP CODE: 21801 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dependent | | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Russell Fitch | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Kathryn Stevens | |
| 19a. INFORMANT'S NAME (Type/Print): Charles R. Fitch | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory 10/27/89 | | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald E. Shofar Jr. | | 22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cor Pulmonale | 1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Bronchopulmonary Dysplasia | 2 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Respiratory Distress Syndrome | immediate |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Prematurity | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pulmonary Interstitial Emphysema

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] Carl Smith Resident | D-19284 | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sinai Hospital of Baltimore, Department of Pediatrics -Northern Pkwy.,Balto., Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | [signature] Jane Davidson-Randall |

DHMH-16 Rev 1/89

89 29518

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Brenda R. Taylor | | | 2. DATE OF DEATH (Month, Day, Year): 10-26-89 | 3. TIME OF DEATH: 11:11PM M |
| 4. SOCIAL SECURITY NUMBER: 214-44-1124 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-28-42 | 8. BIRTHPLACE (State or Foreign Country): Brooklyn N.Y. |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4262 Flowerton Road | | 10f. ZIP CODE: 21229 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 4th | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled | | 16b. KIND OF BUSINESS/INDUSTRY: disabled |
| 17. FATHER'S NAME (First, Middle, Last): Earl A.Dabney | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Orda Greene | | |
| 19a. INFORMANT'S NAME (Type/Print): Orda Dabney | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3211 Ferndale | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Brown-Thompson Funeral Home P.O.Box 4433, Baltimore, Maryland 21223 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pulmonary thromboembolism
DUE TO (OR AS A CONSEQUENCE OF):
Leg vein thrombosis

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 28. PLACE OF DEATH (Check only one) | |
|---|---|---|
| ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 26c. INJURY AT WORK? | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,MD 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | [signature] |

OHMH-16 Rev 1/89

89 29518

8 072 97 89 29519
TAYLOR, THOMAS

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS A TAYLOR | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 28, 1989 | 3. TIME OF DEATH: 10:10A M |
| 4. SOCIAL SECURITY NUMBER: 227-38-7896 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-09-33 |
| 8. BIRTHPLACE (State or Foreign Country): VA | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALT | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1717 PORT ST | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: KOREAN | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABOR | 16b. KIND OF BUSINESS/INDUSTRY: CUSTODIAN | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES E. TAYLOR | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DOROTHY BELL NEWTON | | |
| 19a. INFORMANT'S NAME (Type/Print): GENEL FOREST | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1717 PORT ST BALT MD 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VA CEM. | 20c. LOCATION — City or Town, State: OWINGS MILLS MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 1129 N. CAROLINE ST. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | HYPONA | 1 HR |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | TRACHEAL OBSTRUCTION | 3-4 Days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | ESOPHAGEAL CANCER | 1½ yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-18 Rev 1/89

89 29520

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): IRVIN TILLER JR | | | 2. DATE OF DEATH: MONTH 10 DAY 27 YEAR 89 | 3. TIME OF DEATH: 10:35 p M |
| 4. SOCIAL SECURITY NUMBER: 292 34 3138 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 56 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6 26 1933 | 8. BIRTHPLACE (State or Foreign Country): Ohio |
| 9a. FACILITY NAME (If not institution, give street and number): Loch Raven V. A. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Woodlawn | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] ND |
| 10e. STREET AND NUMBER: 8 Lenis Ct. | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lenmar Lacqner | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Irvin Tiller | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ophelia Bowler | |
| 19a. INFORMANT'S NAME (Type/Print): Hazel Tiller | | 19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Lenis Ct., Balto., Md. 21207 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem. | 20c. LOCATION — City or Town, State: Owings Mills, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Ebron | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Thrombosis of Right femoral graft | 2 mo. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | Above the Knee Amputation of right leg | 2 mo. |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: persisent pyrexia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Patrick Hamilton M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BADAK JAMASBI | | |
| 31. DATE FILED (Month, Day, Year): 10/29/1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29521

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALICE E. URSPRUCH | | | 2. DATE OF DEATH: MONTH 10 DAY 25 YEAR 89 | 3. TIME OF DEATH: 445 P M |
| 4. SOCIAL SECURITY NUMBER: 217-07-1913 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 07-23-11 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): PEATON HOSP AND MED CTR | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3047 Oak Forest Dr. | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yr's; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas McManus | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Morgereth | |
| 19a. INFORMANT'S NAME (Type/Print): Michael Radcliffe, Esq. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 Baltimore Ave. Baltimore, Md. 21204 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery 10/30/89 | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock Jr | | 22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS UNKNOWN SOURCE | 15 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PERSISTENT VEGETATIVE STATE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James Michael Lorman | 29c. LICENSE NUMBER: 027394 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 614 S. CHARLES ST. BALTO. MD 21230

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-15 Rev 1/89

89 29521

OCT 31 1989

89 29522

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MATILDA M. VANN | | | | 2. DATE OF DEATH (Month, Day, Year): 10-26-89 | | 3. TIME OF DEATH: 6:20pm M |
| 4. SOCIAL SECURITY NUMBER: 240 74 3182 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Aug. 25, 1903 | 8. BIRTHPLACE (State or Foreign Country): NC |
| 9a. FACILITY NAME (If not institution, give street and number): 9101 Bridgewater Street | | | 9b. CITY, TOWN OR LOCATION OF DEATH: College Park | | 9c. COUNTY OF DEATH: Prince Georges | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: NC | 10b. COUNTY: Nash | 10c. CITY, TOWN OR LOCATION: Spring Hope | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Box 86 | | 10f. ZIP CODE: 20740 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Elementary School |
| 17. FATHER'S NAME (First, Middle, Last): John Walter Mayo | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Joel Ann Deborah Smithwick | |
| 19a. INFORMANT'S NAME (Type/Print): Matilda J. Turner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same address as #9 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oakdale Cemetery | 20c. LOCATION — City or Town, State: Spring Hope, NC |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes Arlington, Va. 22201 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such ss cerdiec or respiratory srrest, shock, or heert feilure. List Dnly Dne ceuse Dn each line.

| | | Approximste Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CHRONIC LYMPHOCYTIC LEUKEMIA | 6 1/2 YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James G. Brown MD | 29c. LICENSE NUMBER: D07285 | 29d. DATE SIGNED (Month, Day, Year): 10/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES A. BROWN, MD, FACP 14808 PHYSICIANS LANE #212 ROCKVILLE MD 20850 | | |
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph | |

DHMH-16 Rev 1/89

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

5

Item4 11-22-89 FilmG657 W.H.Per F/H

89 29523

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): FRANCES WESOLOWSKI | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 30, 1989 | 3. TIME OF DEATH: 3:58 AM |
| 4. SOCIAL SECURITY NO.: ~~222-18-2877~~ ~~220-28-2277~~ | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 15, 1927 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1228 Glenhaven Rd. | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1228 Glenhaven Rd. | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Frank Maliszewski | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Skalinski | | |
| 19a. INFORMANT'S NAME (Type/Print): David Wesolowski | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8612 Saxon Circle Baltimore, Md. 21236 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Burnside Jr. JAMES F. Burnside, Jr. | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO PULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PANCREATIC CARCINOMA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION
DEHYDRATION

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: A Tokayer MD | 29c. LICENSE NUMBER: D88297 | 29d. DATE SIGNED (Month, Day, Year): 10/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A TOKAYER - JOHNS HOPKINS HOSPITAL | | |
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

5.

89 29524

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETTY LEE WIRTZ

2. DATE OF DEATH (Month, Day, Year): 10 27 1989

3. TIME OF DEATH: 7:36 A. M

4. SOCIAL SECURITY NUMBER: 212-30-5355

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): 07/29/1927

8. BIRTHPLACE (State or Foreign Country): BALTIMORE, MD

9a. FACILITY NAME (If not institution, give street and number): G.B.M.C.-6701 N. CHARLES ST.

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD

9c. COUNTY OF DEATH: BALTIMORE COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE CITY

10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 810-F WILSON POINT RD

10f. ZIP CODE: 21220

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Groomer

16b. KIND OF BUSINESS/INDUSTRY: Animals

17. FATHER'S NAME (First, Middle, Last): Edwin Hinks

18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Funsten

19a. INFORMANT'S NAME (Type/Print): Mr. Donald Wirtz

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3520 Belmont Ave. Glyndon, Md. 21071

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Cemetery

20c. LOCATION — City or Town, State: Baltimore, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Sherman Denny, Jr.

22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CEREBRAL ANOXIA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CVA
DUE TO (OR AS A CONSEQUENCE OF):
c. SMALL VESSEL VASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEPSIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jose O. Delgado

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOSE O. DELGADO M.D.-6701 N. CHARLES ST, BALTIMORE, MD. 21204

31. DATE FILED (Month, Day, Year): OCT 31 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29525

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ROSS F | WHITE | SR | 10 24 89 | 1.56 AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216 01 3601 | 1 [X] M 2 [ ] F | 83 YRS. | | | Dec. 31, 1905 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Pasadena | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1452 Colony Rd. | 21122 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [XX] NO | 1 [ ] YES 2 [XX] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6 | | Serviceman / Repair | Oil Burner Co. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Frank White | Bessie Hudgins |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Walter for Bertha L.White | 1452 Colony Rd., Pasadena, Maryland 21122 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Meadowridge Memorial Park | Elkridge, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Stephen D. Schumm | McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Upper Gastrointestinal Bleeding | 3 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Arteriosclerotic cardiovascular disease | 5 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Chronic Obstructive Pulmonary Disease | 10 years |
| d. | Asbestos lung disease | 20 years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Elliott Gorbaty | D20947 | ▶ 10/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 29) (Type, Print)

ELLIOTT GORBATY, M.D. 7845 OAKWOOD ROAD #203 GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29526

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): HOWARD FREDERICK WHITEHURST, JR.

2. DATE OF DEATH (Month, Day, Year): OCTOBER 26, 1989

3. TIME OF DEATH: 12:45 P. M

4. SOCIAL SECURITY NUMBER: 214 26 3107

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 59 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 3-19-30

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): VA MEDICAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: FORT HOWARD, MARYLAND

9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 5 TAMARAC TRAIL

10f. ZIP CODE: 21220

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [XX] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: KOREAN CONFLICT

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MACHINIST

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): HOWARD FREDERICK WHITEHURST, SR.

18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE PETERS

19a. INFORMANT'S NAME (Type/Print): CLINICAL RECORDS, VAMC

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): VA MEDICAL CENTER FORT HOWARD, MARYLAND 21052

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Cemetery

20c. LOCATION — City or Town, State: BAltimore Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home

22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MaceAVe. 21221

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIOGENIC SHOCK | 2 HOURS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ACUTE MYOCARDIAL INFARCTION | 2 MONTHS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CIRRHOSIS OF LIVER

24a. WAS AN AUTOPSY PERFORMED? 1 [XX] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): 10-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.V.J. VERGHESE, M.D. VA MEDICAL CENTER FORT HOWARD, MD 21052

31. DATE FILED (Month, Day, Year): OCT 31 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29526

OCT 31 1989

89 29527

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNIE L. WILLIAMS | | | | 2. DATE OF DEATH (Month, Day, Year): 10 27 89 | 3. TIME OF DEATH: 10:45A M |
| 4. SOCIAL SECURITY NUMBER: 213-14-8969 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-03-00 | 8. BIRTHPLACE (State or Foreign Country): ATHEN, GA |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1215 N. GAY STREET | | 10f. ZIP CODE: 21213 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | 16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC | |
| 17. FATHER'S NAME (First, Middle, Last): RICHARD BELL | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY | | |
| 19a. INFORMANT'S NAME (Type/Print): ELDER YOUNG | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 254 W. HAZEL STREET/NEW HAVEN, CT 06511 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL PARK | | 20c. LOCATION — City or Town, State: ARBUTUS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vanessa Davis | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ABDOMINAL TUMOR? ABDOMINAL TUMOR? | ? |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. OLD AGE. OLD AGE DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION DEHYDRATION
URINARY INFECTION URINARY INFECTION

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| A. Nazemi M.D. | CHURCH H | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Gina Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29528

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM E. WHITE Sr.

2. DATE OF DEATH (Month, Day, Year): 10 26 89

3. TIME OF DEATH: 12:50 p M

4. SOCIAL SECURITY NUMBER: 717-07-5497

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 71 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 7-26-18

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Perry Point V.A. Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point,Md.

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: Baltimore

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 3442 Woodstock Avenue

10f. ZIP CODE: 21213

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Longshoreman

16b. KIND OF BUSINESS/INDUSTRY: I.T.O.

17. FATHER'S NAME (First, Middle, Last): James H. White

18. MOTHER'S NAME (First, Middle, Maiden Surname): Amy DEckman

19a. INFORMANT'S NAME (Type/Print): Mary T. White

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3442 Woodstock Avenue Baltimore,Maryland-21213

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy REdeemer Cemetery

20c. LOCATION — City or Town, State: Baltimore,MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy

22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 BElair Road Balto. Md.-21206

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Secondary to inoperable Cancer of Pancreas
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

25. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [XX] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURRED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mahmut Atay MD

29c. LICENSE NUMBER: D19335

29d. DATE SIGNED (Month, Day, Year): ▶ Oct. 26, 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MAHMUT ATAY, M.D.

31. DATE FILED (Month, Day, Year): OCT 31 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

88 54258

89 29529

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Robert Young
2. DATE OF DEATH — MONTH: 10 DAY: 28 YEAR: 89
3. TIME OF DEATH: 10:30 AM M
4. SOCIAL SECURITY NUMBER: 212-36-7761
5. SEX: [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 47 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/22/42
8. BIRTHPLACE (State or Foreign Country): Chester, SC
9a. FACILITY NAME (If not institution, give street and number): Univ. of Maryland Cancer Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 917 N. Washington Street
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEOENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4 or 6+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): Wade N. Young
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Hinton
19a. INFORMANT'S NAME (Type/Print): Frances Young
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 917 N Washington St. Balto. Md 21205
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park
20c. LOCATION — City or Town, State: Randallstown, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Julia R. March
22. NAME AND ADDRESS OF FACILITY: WM. C. March F. H. 1101 E. North Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Widespread Macroglobulinemia
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 6 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D33472
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HOWARD PARNES M.D
31. DATE FILED (Month, Day, Year): 10/31/1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 29530

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Charles | Anderson | 10-29-89 | 8:30AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-09-9544 | XX 1 M 2 F | 89 YRS. | | | 4-9-1900 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 2000 O'Dell | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | XX 1 YES 2 NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2000 ODELL AVENURE APT. 811 | 21237 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married XX 3 Widowed 4 Divorced | 1 YES 2 XX NO | 1 YES XX 2 NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| UNKNOWN | | SANITATION | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM ANDERSON | NA |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ESTELLA CHAMBERS | 301 McMECHEN STREET/BALTIMORE, MD 21237 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | WESTERN STAR CEMETERY | CATONSVILLE, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| John B. Johnson | WM. C. MARCH F.H. 1101 E. NORTH AVENUE 21202 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 YES XX NO | 1 YES XX NO |
| INQUIRY | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home XX 5 Residence 6 Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| XX 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined | | | 1 YES 2 NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin, M.D. | OCME | ▶ 10-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. 111 Penn Street, baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 53230

89 29531

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PEARL ALLEN | | | 2. DATE OF DEATH (Month, Day, Year): 10 29 89 | 3. TIME OF DEATH: 10 30 PM |
| 4. SOCIAL SECURITY NUMBER: 219-26-9963A | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/29/02 | 8. BIRTHPLACE (State or Foreign Country): Balto County, Md |
| 9a. FACILITY NAME (If not institution, give street and number): Union Mem. Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. Md. | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTO. | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2216 Hamilton Ave | | 10f. ZIP CODE: 21214 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Distance | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY BROOKS | | |
| 19a. INFORMANT'S NAME (Type/Print): David Barugh | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2216 Hamilton Ave Balto. Md 21214 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Calvary Cem. | | 20c. LOCATION — City or Town, State: A.A. County. Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph G. Locke Jr | | 22. NAME AND ADDRESS OF FACILITY: Locke Funeral Home 1304 N. Central Ave | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HYPERKALEMIA | Immediate |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal Failure | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal bleeding / severe Anemia

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO: N/A | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: N/A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO: N/A |
| | 28d. DESCRIBE HOW INJURY OCCURED: N/A | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: David N. Lubarsky MD | 29c. LICENSE NUMBER: D35572 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Lubia Davidson-Randall | |

DHMH-16 Rev 1/89

88 52231

89 29532

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Baffour~~ Richard Barbour
2. DATE OF DEATH (Month, Day, Year): 10 - 26 - 89
3. TIME OF DEATH: 5:12 AM
4. SOCIAL SECURITY NUMBER: 215-46-6156
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 42 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-28-47
8. BIRTHPLACE (State or Foreign Country): BALTO, MD
8a. FACILITY NAME (If not institution, give street and number): KEY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2747 SCARBOROUGH CIRCLE
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BENS TENDER
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): RICHARD - BARBOUR
18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE - STARLES
19a. INFORMANT'S NAME (Type/Print): JUDY BARBOUR
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2747 SCARBOROUGH CIRCLE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KITTUR MEMORIAL PARK
20c. LOCATION — City or Town, State: BALTIMORE, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Smitha Hector #281
22. NAME AND ADDRESS OF FACILITY: EL. PHILLIPS FUNERAL HM 1721 N. MONROE STREET. 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ~~Undetermined~~ Cardiac Asystole — 30 minutes

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ~~Cardiac Asystole~~ Undetermined etiology

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Transplant 10/13/89
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Yekaterina Jones M.D.
29c. LICENSE NUMBER: D 21585
29d. DATE SIGNED (Month, Day, Year): 10/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. S. KITTUR, JHMC, BALTIMORE, MD 21224
31. DATE FILED: NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29532

89 29533

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RENA MAE BYRD
2. DATE OF DEATH (Month, Day, Year): 10 28 89
3. TIME OF DEATH: 8:15 PM M
4. SOCIAL SECURITY NUMBER: 213-07-8993
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 7-5-97
8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSP. ECU
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1605 E 30th STREET
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Walter Jones
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth
19a. INFORMANT'S NAME (Type/Print): Delilah E. Davis
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1605 East 30th Street Baltimore, Maryland 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park
20c. LOCATION — City or Town, State: Balto. County, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. END STAGE ALZHEIMER'S DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
UTI
ATRIAL FIBRILLATION
MALNUTRITION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation e ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Alicia Hook-Foley MD
29c. LICENSE NUMBER: D 30717
29d. DATE SIGNED (Month, Day, Year) ▶ 10/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print)
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

ITEM:23part2 DELETED FROM CERT
per DR G-663 5-7-90 cm

89 29534

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PERRY BLACK BULLOCK
2. DATE OF DEATH (Month, Day, Year): 10 28 89
3. TIME OF DEATH: 6 30 P M
4. SOCIAL SECURITY NUMBER: 216-46-7658
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAY 22 1909
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): MANOR CARE RUXTON
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON MD.
9c. COUNTY OF DEATH: BALTIMORE.

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: LUTHERVILLE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1718 BROADWAY
10f. ZIP CODE: 21093
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: OWN HOME
17. FATHER'S NAME (First, Middle, Last): VAN LEAR BLACK
18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE O. GARY
19a. INFORMANT'S NAME (Type/Print): PERRY J. BOLTON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOX 136 BROOKLANDVILLE MD. 21022
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GREEN MT. CREMATORY
20c. LOCATION — City or Town, State: BALTIMORE MD. 21201
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. M. Perkins Jr.
22. NAME AND ADDRESS OF FACILITY: H.W. JENKINS AND SONS CO. 4905 YORK RD. BALTO. MD. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARCINOMA OF THE LUNG — Approximate Interval: 22 MO.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. SMOKING, COPD
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John A. Nesbitt III MD
29c. LICENSE NUMBER: D14623
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN A. NESBITT, III MD 201 E. UNIV. PKWY, BALT. MD. 21218
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29535

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Tyrone Bryant
2. DATE OF DEATH — MONTH: 10 DAY: 29 YEAR: 89
3. TIME OF DEATH: 9:00 A M
4. SOCIAL SECURITY NUMBER: 216-54-6350
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 40 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/28/49
8. BIRTHPLACE (State or Foreign Country): N. Carolina
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT:

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore Md.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2807 W. Garrison Ave.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Willie Bryant
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Washington
19a. INFORMANT'S NAME (Type/Print): Denise Bryant
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2807 W. Garrison Ave 21215

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Zion Cem.
20c. LOCATION — City or Town, State: Baltimore Co.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J.K. Russ Funeral Dir.
22. NAME AND ADDRESS OF FACILITY: 2222 W. North Ave. 21216

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
e. GI Bleeding — DUE TO (OR AS A CONSEQUENCE OF): — one week

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Esophageal Varices / Peptic Ulcer Disease — DUE TO (OR AS A CONSEQUENCE OF):
c. Alcoholism — DUE TO (OR AS A CONSEQUENCE OF):
d. — DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

648

89 29536

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Olivia I. BARNES
2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89
3. TIME OF DEATH: 2:30 PM
4. SOCIAL SECURITY NUMBER: 226-30-6035
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04/19/27
8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTO
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5219 WILTON HEIGHTS AVE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRINTER
16b. KIND OF BUSINESS/INDUSTRY: ALEX BROWN + SONS
17. FATHER'S NAME (First, Middle, Last): MOSE WALTHALL
18. MOTHER'S NAME (First, Middle, Maiden Surname): EULA Hamlett
19a. INFORMANT'S NAME (Type/Print): BEATRICE RATLIFF
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 917 CHESTNUT HILL ROAD Balto, MD 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRISON Forest VA Cem
20c. LOCATION — City or Town, State: Owings Mills, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy Harris
22. NAME AND ADDRESS OF FACILITY: CHATMAN-HARRIS F.H. 1201 McCulloh St Baltimore, MD 21217

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Pancreatic CA ⊂ mets to Abdomen | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Pulmonary Edema | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | Peritonitis | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jon A. Hassman
29c. LICENSE NUMBER: SINAI H.O.
29d. DATE SIGNED (Month, Day, Year): 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J HASSMAN 640 HARVEY ST BALTO MD 21230
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29537

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie A. Bourne
2. DATE OF DEATH (Month, Day, Year): 10 28 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-38-2005
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 49 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5 26 40
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 633 Radnor Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 633 Radnor Avenue
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Claims Adjuster
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Charles L. Brown, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie A. Jones
19a. INFORMANT'S NAME (Type/Print): Thomas H. Bourne, 3rd
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 Gibson Road Baltimore, Maryland 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park
20c. LOCATION — City or Town, State: Randallstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Berry Harris
22. NAME AND ADDRESS OF FACILITY: 1701 McCulloh St, Chatman-Harris F/H Baltimore, Md 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio-pulmonary Arrest.
DUE TO (OR AS A CONSEQUENCE OF):
b. Chronic Aspiration pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
c. ? Old CVA
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Pulmonary tuberculosis
Malnutrition

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D25391
29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5601 - Loch Raven Blvd, Baltimore Maryland 21239
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29538

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Carroll BIDDISON
2. DATE OF DEATH (Month, Day, Year): 10 27 1989
3. TIME OF DEATH: 1:30 P M
4. SOCIAL SECURITY NUMBER: 216-05-4740A
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 86 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): Sept. 11, 1903
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hos.
9b. CITY, TOWN OR LOCATION OF DEATH: Rossville
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Kingsville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11702 Bellvue Ave.
10f. ZIP CODE: 21087
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 yrs. College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Rtd. salesman
16b. KIND OF BUSINESS/INDUSTRY: H.Cohnstan , N.Y.
17. FATHER'S NAME (First, Middle, Last): Jess Biddison
18. MOTHER'S NAME (First, Middle, Maiden Surname): Zang
19a. INFORMANT'S NAME (Type/Print): Mr. James G. Biddison
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4428 Medolyn Rd. Perry Hall, Md. 21128
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Joseph Church Cem. Fullerton,
20c. LOCATION — City or Town, State: Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jonathan F. H.
22. NAME AND ADDRESS OF FACILITY: 11750 Belair Rd. Kingsville, Md. 21087

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Myelofibrosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Heart Failure
Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Myo Thant
29c. LICENSE NUMBER: D18487
29d. DATE SIGNED (Month, Day, Year): ▶ October 27, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Myo Thant, MD 9101 Franklin Square Drive Baltimore, Md. 21237
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29539

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dolores A. Boglia
2. DATE OF DEATH (Month, Day, Year): October 29, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 220-54-5608
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 9, 1907
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3506 Ailsa Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3506 Ailsa Ave.
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 1 year
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): George Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Behr
19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia Ann Kirby
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12 Flanders Ridge Ave. Cockeysville, Md. 21030
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus 11/2/89
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Paul L. Hartsock, Jr. ▶ Paul L. Hartsock, Jr.
22. NAME AND ADDRESS OF FACILITY: Baltimore, Maryland 21214 — Leonard J. Ruck, Inc. 5305 Harford Rd.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Carcinoma of the Lung | 2 years |
| DUE TO (OR AS A CONSEQUENCE OF): b. | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D19423
29d. DATE SIGNED (Month, Day, Year) ▶ 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward Miller, M.D., Russell H. Morgan Prof. Bldg., 5601 Loch Raven Blvd., Balto., Md. 21239
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Judie Davidson-Randall

DHMH-18 Rev 1/89

89 29540

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frank Burrell
2. DATE OF DEATH (Month, Day, Year): Oct. 22 89
3. TIME OF DEATH: 1110 A M
4. SOCIAL SECURITY NUMBER: 244-18-8089
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): 89 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/12/1900
8. BIRTHPLACE (State or Foreign Country): Townsville, NC
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Sil. Spg
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Mont
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 11809 Old Columbia Pike
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? Usa
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): High School — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): John Thomas Burrell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unk
19a. INFORMANT'S NAME (Type/Print): Emma Carpenter (Daughter)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a,b,c,d,e,&f
20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Memorial Park
20c. LOCATION — City or Town, State: Landover, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: John T Rhines Co, 3015 12th Street NE, DC 20017

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Dis
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstr. Pul. Dis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 XX DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Rogers MD
29c. LICENSE NUMBER: D0 22910
29d. DATE SIGNED (Month, Day, Year): ▶ Oct 27 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible]
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: [signature] Randall

DHMH-16 Rev 1/89

89 29541

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BRUCE A. CHASE | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 27 / 89 | 3. TIME OF DEATH: 03:20PM |
| 4. SOCIAL SECURITY NUMBER: 214-50-8258 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 42 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): AUG. 30, 1947 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 835 HOLLINS ST. | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1966 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRODUCE MANAGER | 16b. KIND OF BUSINESS/INDUSTRY: FOOD |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): ROBERT E. CHASE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE ELIZABETH N/A |
| 19a. INFORMANT'S NAME (Type/Print): SAMUEL A. MACATEE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1307 JOHN ST BALTIMORE MD. 21217 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE MD. 21229 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William R. Chase III | 22. NAME AND ADDRESS OF FACILITY: H.W. JENKINS AND SONS CO. 4905 YORK RD. BALTO. MD. 21212 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | 3 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): PNEUMOCYSTIS CARINII (PNEUMONIA) PNEUMONIA | 21 DAYS |
| | c. DUE TO (OR AS A CONSEQUENCE OF): ACQUIRED IMMUNODEFICIENCY SYNDROME | 17 MONTHS |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29e. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: D. J. DeRasica MD | 29c. LICENSE NUMBER: JHH # A9137 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONALD J. DERASICA 600 N. WOLFE ST. BALTIMORE, MD 21215

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

93 · 1 CHASE, BRUCE A 8-232 10/30/47

89 29542

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Byron Keith Crawford | | | 2. DATE OF DEATH (Month, Day, Year): 10-30-89 | 3. TIME OF DEATH: 10:45AM M |
| 4. SOCIAL SECURITY NUMBER: 212-78-8515 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 21 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/27/68 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1514 West Pratt Street | | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): G.E.D. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouseman | 16b. KIND OF BUSINESS/INDUSTRY: National Wildlife | |
| 17. FATHER'S NAME (First, Middle, Last): James L. Crawford | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Beverly I. Helbley | |
| 19a. INFORMANT'S NAME (Type/Print): James L. Crawford | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1514 West Pratt Street Baltimore, Md. 21223 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jackie D. Shannon | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Blunt Force Trauma to Head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: XX [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XX [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10-29-89 | 28b. TIME OF INJURY: 8:00PM | 28c. INJURY AT WORK? 1 [ ] YES XX [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject beaten |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 1500 blk. W. Pratt Street, Baltimore City, Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr., MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-31-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,MD 111 Penn Street,Baltimore,MD 21201 | | VC |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29543

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages: 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ADELE | I. | CLARK | Oct. 31, 1989 | 12:40 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-01-0933 | 1 ☐ M 2 ☒ F | 77 YRS. | | | 7-28-1912 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Dulaney Towson Nursing Home | Towson | Baltimore Co. |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore County | Towson | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1503 Dellsway Road | 21204 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 Years | ---------- | Bookkeeper | Printing |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William H. Baynes | Elizabeth Grieb |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Natalie E. Marcin | 1503 Dellsway Road Towson, Maryland 21204 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Parkwood Cemetery | Balto. Co., Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | William E. Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21204 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Generalized Atherosclerosis | yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | | ▶ 11-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Robert E. Stoner, MD Suite 506 120 Sisson Pierre Rd. 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

Item 4 11-2-89 film 657 LH

89 29544

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Cartier | | | 2. DATE OF DEATH (Month, Day, Year): 10 26 89 | 3. TIME OF DEATH: 230A M |
| 4. SOCIAL SECURITY NUMBER: 220-03-0070 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/7/21 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MED CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1522 Pulaski STREET | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.): RETIRED |
| | | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): RAYMOND STAFFORD | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LESLIE Soloman |
| 19a. INFORMANT'S NAME (Type/Print): IRENE DIXON | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1522 Pulaski STREET 21217 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge CEMT. | 20c. LOCATION — City or Town, State: BALTIMORE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Martha Koch 251 | 22. NAME AND ADDRESS OF FACILITY: E.L. Phillips 1721 N. Monroe St. 21217 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Adult Respiratory distress Syndrome | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ahmed Hossain | 29c. LICENSE NUMBER: D37353 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/26/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ahmed Hossain | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29545

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

7

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM HOWARD COOK | | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 89 | 3. TIME OF DEATH: 05 10 a M |
| 4. SOCIAL SECURITY NUMBER: 232-14-0295 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-15-1908 | 8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: HARFORD | 10c. CITY, TOWN OR LOCATION: JOPPA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 3409 CLAYTON ROAD | | 10f. ZIP CODE: 21085 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH GRADE; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COAL MINER | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): FLLOYD COOK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MANERVA NOT KNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): HANSFORD COOK | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1402 SALISBURY COURT JOPPA, MARYLAND 21085 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL 10-30-1989 | 20c. LOCATION — City or Town, State: DORSEY, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gene P. Gardner | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 X NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Wm D. Trowbridge M.D. | 29c. LICENSE NUMBER: D 38737 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CALABRESE, MD FSK Med Center Balt, MD. 21224. | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29546

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Brinton Conner II
2. DATE OF DEATH (Month, Day, Year): 10 29 89
3. TIME OF DEATH: 2142 M
4. SOCIAL SECURITY NUMBER: 098-09-8467
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 78 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 6, 1911
8. BIRTHPLACE (State or Foreign Country): Ocean City, MD.
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY
9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Worcester
10c. CITY, TOWN OR LOCATION: Ocean City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 320 Bayshore Dr.
10f. ZIP CODE: 21842
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: WW II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cyberneticist Chemical Engineer
16b. KIND OF BUSINESS/INDUSTRY: Chemical
17. FATHER'S NAME (First, Middle, Last): George Brinton Conner
18. MOTHER'S NAME (First, Middle, Maiden Surname): Willye Jones
19a. INFORMANT'S NAME (Type/Print): Edmund B. Conner
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Bishopville, MD. 21813 (11045 Piney Island Dr.)
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parsons
20c. LOCATION — City or Town, State: Salisbury, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Burbage Funeral Home, 108 Williams St., Berlin, Md. 21811

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Uremia, Renal Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | End-stage Renal Disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Chronic Glomerulonephritis | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Constante J Tan M.D.
29c. LICENSE NUMBER: MD 16725
29d. DATE SIGNED (Month, Day, Year) ▶ 10/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CONSTANTE J TAN 547-D Riverside Dr. Salisbury, MD
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 29547

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lonny Lane Cox
2. DATE OF DEATH (Month, Day, Year): 10 30 89
3. TIME OF DEATH: 6:12 a M
4. SOCIAL SECURITY NUMBER: 212-48-7663
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 42 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07/01/47
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Greater Baltimore Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Freeland
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1932 Bulls Saw Mill Road
10f. ZIP CODE: 21053
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 1965-1968
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouse Worker
16b. KIND OF BUSINESS/INDUSTRY: Parts Warehouse
17. FATHER'S NAME (First, Middle, Last): William H. Cox
18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise A. Knarr
19a. INFORMANT'S NAME (Type/Print): Gloria J. Cox
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1932 Bull's Saw Mill Rd., Freeland,MD 21053
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pine Grove Cemetery
20c. LOCATION — City or Town, State: Parkton, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles T. Bowen
22. NAME AND ADDRESS OF FACILITY: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiovascular Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. G.I. Bleed
DUE TO (OR AS A CONSEQUENCE OF):
c. Prostatic CA
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Hairston MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard Hairston,M.D. G.B.M.C.
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29548

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
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**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Katherine Corso | | 10-30-89 | 9:05 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-28-0749 | 1 ☐ M 2 ☒ F | 76 YRS. | | | 11/17/12 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 2176 Sand Hill Road | Marriottsville | Howard County |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Howard | Marriottsville | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2176 Sand Hill Road | 21104 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| unknown | | homemaker | own home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Tony Semilio | Mary Marciano |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Frances M. Gallina | 2176 Sand Hill Rd./Marriottsville, MD 21104 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Gardens of Faith | Baltimore, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Peter J. Corbett | John A. Moran Inc. 3000 E. Baltimore Street 21224 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications thet ceused the deeth. Do not enter the mode of dying, such ss cerdiec or respiratory srrest, shock, or heert failure. Liet only one ceuse on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Metastatic Colon Cancer s/p Colostomy. | |
| Sequentially liet conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Chronic Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Atrial Fibrillation | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. Cardiopulmonary Arrest | |

PART ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i.

D. Hx of Schizophrenia.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature], MD | D19510 | ▶ 10.31.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
10806 Hickory Ridge Rd; Columbia, MD 21044

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 2525

89 29549

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANK DENBY SR.
2. DATE OF DEATH (Month, Day, Year): 10 30 89
3. TIME OF DEATH: 10 30 M
4. SOCIAL SECURITY NUMBER: 577-03-8924
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/23/14
8. BIRTHPLACE (State or Foreign Country): TENN.
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 417 Potomac ~~Street~~ AVE
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES: UNKNOWN
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 ~~UNKNOWN~~ — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN
16b. KIND OF BUSINESS/INDUSTRY: ARMCO STEEL
17. FATHER'S NAME (First, Middle, Last): ROBERT DENBY
18. MOTHER'S NAME (First, Middle, Maiden Surname): JOHN WESLEY ORRAND
19a. INFORMANT'S NAME (Type/Print): JUANITA DENGLER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6189 OLD PIEDMONT RD., SAN JOSE, CA. 95132
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDAN PARK CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Denise L. Forlando
22. NAME AND ADDRESS OF FACILITY: C. VARN/ ROSEDALE FUNERAL HOME, INC. 1211 CHESACO AVE. BALTIMORE, MD. 21237

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Disseminated intravascular coagulation
DUE TO (OR AS A CONSEQUENCE OF):
c. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Cecal mass (unknown etiology)
(2) liver mass

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Warren D. Foreman M.D
29c. LICENSE NUMBER: D38737
29d. DATE SIGNED (Month, Day, Year): ▶ 10-30-89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Collaborate MD. Francis Scott Key Medical Center
31. DATE FILED (Month, Day, Year): 10/ NOV 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

ITEM #7 FILM #G657 PER: F. H. 11/03/89 J. A.
D.J.

89 29550

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

6

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JAMES DARE | | | | 2. DATE OF DEATH: MONTH 10 DAY 26 YEAR 89 | 3. TIME OF DEATH: 1140 P M |
| 4. SOCIAL SECURITY NUMBER: 216 12 0078 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month Day Year): Dec. 12, 1921 | 6. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | | | | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3018 Ferndale Ave. | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: World War II | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer | 16b. KIND OF BUSINESS/INDUSTRY: Federal Government |
| 17. FATHER'S NAME (First, Middle, Last): James Wallace | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Dare | |
| 19a. INFORMANT'S NAME (Type/Print): Beulah Wallace Dare | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3018 Ferndale Ave. Baltimore, Maryland 21207 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veteran Cem. | 20c. LOCATION — City or Town, State: Balto., County, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Vernon R Bailey | | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes. Inc 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | severe peripheral vascular disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Myocardial infaction | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | seizures | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | severe decompensated CHF | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Boonin | 29c. LICENSE NUMBER: D12729 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/26 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TERANCE LAMB LIBERTY MEDICAL CENTER BALTIMORE

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29551

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ANTHONY | L | DAVIDSON | 10 / 23 / 89 | 2.48 AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-26-0596 | 1 [X] M 2 [ ] F | 60 YRS. | | | 10-5-29 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Pasadena | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 214 Arundel Road | 21122 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO — Korean Conflict | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10th Grade | | Carpenter | Macks Contractors |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Joseph Henry Davidson | Agnes Cecilia Keller |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| May Davidson | 214 Arundel Road Pasadena, Maryland 21122 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Glen Haven Memorial Park | Glen Burnie, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Donna M Bramiowski | Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO-PULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. METASTATIC TRANSITIONAL CELL CA BLADDER | 2 YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending investigation 8 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| ZAGULA | | ▶ 10/24/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
325 HOSPITAL DRIVE #204 GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29521

NOV 1 1989

89 29552

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed ... by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CATHERINE M. DURR | | | | 2. DATE OF DEATH (Month, Day, Year): OCT. 28, 1989 | 3. TIME OF DEATH: 12:25 A M |
| 4. SOCIAL SECURITY NUMBER: 217-46-3883 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): OCT. 15, 1905 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): VILLA ST. MICHAELS NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: -- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 325 LAMBETH ROAD | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN DURR | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY HAHN | |
| 19a. INFORMANT'S NAME (Type/Print): HELEN OUSBORNE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 323 LAMBETH ROAD, CATONSVILLE, MD. 21228 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy M. Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebral Thrombosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harold B. Bob MD | 29c. LICENSE NUMBER: D15872 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HAROLD B. BOB 7220 Park Height 21208

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall |

DHMH-18 Rev 1/89

89 29553

1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): EDWARD VERNON DICKERSON

**2. DATE OF DEATH** (Month, Day, Year): OCT. 24, 1989

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 219107988

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 66 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): OCT. 12, 1923

**8. BIRTHPLACE** (State or Foreign Country): MARYLAND

**9a. FACILITY NAME** (If not institution, give street and number): ST. JOSEPH HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: TOWSON

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**: LARNEY

**10d. INSIDE CITY LIMITS?** 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 8711 LITTLEWOOD ROAD

**10f. ZIP CODE**: 21234

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: W.W.II

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: WHITE

**15. DECEOENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 YRS.
College (1-4 or 5 +):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): SECURITY OFFICER

**16b. KIND OF BUSINESS/INDUSTRY**: SCHOOLS BALTO. CO. PUBLIC

**17. FATHER'S NAME** (First, Middle, Last): JAMES A. DICKERSON

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): CLARA ROBINSON

**19a. INFORMANT'S NAME** (Type/Print): FAMILY RECORDS

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): PARKWOOD CEMETERY

**20c. LOCATION — City or Town, State**: PARKVILLE, MD.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ [signature]

**22. NAME AND ADDRESS OF FACILITY**: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Ischemic Cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

Diabetes mellitus

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature]

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 10/26/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): DR. GRACITO PATRICIO 8903 HARFORD ROAD - PARKVILLE

**31. DATE FILED** (Month, Day, Year): NOV 1 1989

**32. REGISTRAR'S SIGNATURE**: Gina Davidson-Handsell

DHMH-16 Rev 1/89

89 29554

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN DOMINICK DITONNO
2. DATE OF DEATH — MONTH: OCT DAY: 27 YEAR: 1989
3. TIME OF DEATH: 1125 P M
4. SOCIAL SECURITY NUMBER: 213-34-6545
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 52 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): JUNE 29 1937
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSP.
9b. CITY, TOWN OR LOCATION OF DEATH: ROSEDALE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: PARKVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3 ROBIN RIDGE COURT
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2 years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): QUALITY CONTROL
16b. KIND OF BUSINESS/INDUSTRY: W. R. GRACE & CO.
17. FATHER'S NAME (First, Middle, Last): JOHN A. DITONNO
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARIE GRYCZKOWSKI
19a. INFORMANT'S NAME (Type/Print): MARIE DITONNO
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 ROBIN RIDGE COURT 21234
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER CEM.
20c. LOCATION — City or Town, State: BALTO. CITY, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frances C. Evans
22. NAME AND ADDRESS OF FACILITY: Evans Chapel of Memories

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF): — Immediate
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley Felsen M.D. Deputy Medical EXAMINER
29c. LICENSE NUMBER: D0108[illegible]
29d. DATE SIGNED (Month, Day, Year): ▶ Oct 28/1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY Z. Felsen MD 11 E. Chase St Baltimore
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Zeta Davidson-Randolph

OHMH-16 Rev 1/89

89 29555

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNA M DONAHOE, ANNA M.
2. DATE OF DEATH (Month, Day, Year): 10 - 29 - 89
3. TIME OF DEATH: 9:30 A.M.
4. SOCIAL SECURITY NUMBER: 171-07-0041
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 12/09/08
8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY BALTIMORE MD
9c. COUNTY OF DEATH: BALTIMORE BALT.

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6940 BROENING ROAD
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Clerical
16b. KIND OF BUSINESS/INDUSTRY: United Oil

17. FATHER'S NAME (First, Middle, Last): Harry Fellows
18. MOTHER'S NAME (First, Middle, Maiden Surname): ?

19a. INFORMANT'S NAME (Type/Print): Elizabeth Reynolds
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6940 Broening Rd.Balto.,Md.21222

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Mem. Park
20c. LOCATION — City or Town, State: Howard Co.,MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William S. De
22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley Funeral Home,In 2134 Willow Spring Rd.Dundalk,MD.21222

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC OVARIAN CARCINOMA | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. (1) METASTATIC OVARIAN CARCINOMA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | b. (2) INTESTINAL OBSTRUCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Terance L. Lamb Medical Hospital specialist
29c. LICENSE NUMBER: D37203 D37203
29d. DATE SIGNED (Month, Day, Year): ▶ 10-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type or Print): TERANCE L. LAMB CHURCH HOSPITAL BALTIMORE, MARYLAND TERANCE L. LAMB CHURCH HOSPITAL BALTIMORE, MD
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Gene Davidson-Randall

OHMH-16 Rev 1/89

89 29556

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Timothy JOSEPH Epps SR.
2. DATE OF DEATH (Month, Day, Year): 10 27 89
3. TIME OF DEATH: 7:46 A M
4. SOCIAL SECURITY NUMBER: 212-44-9249
5. SEX: 1 M 2 F
6. AGE (In yrs. last birthday): 44 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)
7. DATE OF BIRTH (Month, Day, Year): 10-27-45
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 YES 2 NO
10e. STREET AND NUMBER: 2915 EDGECOMB CIRCLE-NORTH
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): JAMES EPPS
18. MOTHER'S NAME (First, Middle, Maiden Surname): BERNICE HUDSON
19a. INFORMANT'S NAME (Type/Print): YVONNE EPPS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2915 EDGECOMB CIRCLE-NORTH/BALTO. MD 21215
20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY
20c. LOCATION — City or Town, State: ANNE ARUNDEL, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin L. Willis
22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVENUE 21202

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)
27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 YES 2 NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto.MD.
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29557

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 of 3 pages
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDITH ENNIS EDITH ENNIS | | | | 2. DATE OF DEATH (Month, Day, Year): 10 29 89 | 3. TIME OF DEATH: 356 AM |
| 4. SOCIAL SECURITY NUMBER: 217-24-9347 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/17/01 | 8. BIRTHPLACE (State or Foreign Country): RUSSIA |
| 9a. FACILITY NAME (If not institution, give street and number): SUBURBAN HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA, MD. | | 9c. COUNTY OF DEATH: MONTGOMERY |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 11 SLADE AVE. APT. 704 | | 10f. ZIP CODE: 21208 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKER | |
| 17. FATHER'S NAME (First, Middle, Last): JOSEPH CHOLETT | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA UNKNOWN | | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. DEBORAH KREITER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7025 TILDEN LANE ROCKVILLE, MD. ( 20852) | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON CEMETERY | | 20c. LOCATION — City or Town, State: BALTIMORE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney L. Stillman | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO-PULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASPIRATION OF INTESTINAL CONTENTS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. INTRA-ABDOMINAL CATASTROPHE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ira Miller M.D. | 09267 | ▶ 10-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ira Miller M.D. 8218 Wisconsin Ave. Bethesda, Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29558

1 FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): MYRTLE L. ENDRESS
2. DATE OF DEATH (Month, Day, Year): OCT. 25, 1989
3. TIME OF DEATH: 10:30 A.M.
4. SOCIAL SECURITY NUMBER: 214-03-1705A
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): OCT 24, 1903
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): HOLLY HILL MANOR
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

**RESIDENCE OF DECEDENT**

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: CARNEY
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9004 HINES ROAD
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 YRS. | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): JOHN T. ALLISON, SR
18. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISE K. NERF
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY
20c. LOCATION — City or Town, State: ESSEX, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph T. Evans, Jr.
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8300 HARFORD ROAD-PARKVILLE

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ischemia of leg — 1 week
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Peripheral vascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Atherosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes mellitus
Senile dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Carl Friedman MD
29c. LICENSE NUMBER: D20688
29d. DATE SIGNED (Month, Day, Year): ▶ 10/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. CARL FRIEDMAN 660 KENILWORTH DRIVE-TOWSON
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL, DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 051 94 09 A
FREEDLANDER, LEAH S
07/24/16 E
89 29559

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| LEAH S ~~FREEDLANDER~~ FREEDLANDER | OCTOBER 26, 1989 | 3:10A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-30-4175 | 1 ☐ M 2 ☒ F | 73 YRS. | | | 2/24/16 | NEW YORK |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | | BALTIMORE | 1 ☐ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 15 ST. GEORGES RD. | 21210 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| SIDNEY STARK | SADIE ABRAMOWITZ |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MAURICE FREEDLANDER (spouse) | 15 ST. GEORGES RD., BALTIMORE, MD. 21210 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) _____ | | |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Ronald A Wade 10-31-89 | STATE ANATOMY BOARD, BALTO., MD. 21201 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | 3d |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Wound infection | 1 wk |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Metastatic Breast Disease | 1 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Breast Carcinoma | 10 yrs |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | JOHNS HOPKINS HOSPITAL |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Linda M. Mundy | | ▶ 10/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda M. Mundy JOHNS HOPKINS HOSPITAL

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | [illegible] |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29560

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Diana Faidley
2. DATE OF DEATH — MONTH: 10 DAY: 28 YEAR: 89
3. TIME OF DEATH: 1:25 P (M)
4. SOCIAL SECURITY NUMBER: 212-74-1986
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/30/05
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not institution, give street and number): ST JOSEPH HOSPITAL, INC
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALT

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALT.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 405 E 22ND ST
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? US.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negro
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): George Dupee
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edmonia Gilmore
19a. INFORMANT'S NAME (Type/Print): Grace Willis
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 405 E 22nd St. 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Pk.
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2222 W. North Ave 21216

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic liver disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. metastatic colon cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
cachexia, anemia
SIP sigmoid colon resection

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: A. Tamburrino
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Tamburrino
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

89 29560

Item#2 Film#g657 11/09/89 da per F.H.

89 29561

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHY E. FOY
2. DATE OF DEATH: MONTH 10 DAY ~~24~~ 23 YEAR 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 219 50 6589
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11 20 18
8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2812 WINCHESTER STREET
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY?: US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: BLACK
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMTRESS
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): HARRISON P. PAGE
18. MOTHER'S NAME (First, Middle, Maiden Surname): ADDIE ALLEN
19a. INFORMANT'S NAME (Type/Print): WILLIAM A. FOY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2812 WINCHESTER STREET BALTO. MD. 21216
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEM. PARK
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: #281
22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721-27 MONROE STREET 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF): b. Pulmonary Embolus

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Thrombophlebitis

DUE TO (OR AS A CONSEQUENCE OF): d. Postmenopausal Adenocarcinoma

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Uterine Adenocarcinoma Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D18847
29d. DATE SIGNED (Month, Day, Year): ▶ 10-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] BROWN MD [illegible]

31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 2952

89 29562

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY ELAINE FOWLER

2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89

3. TIME OF DEATH: 1540 P M

4. SOCIAL SECURITY NUMBER: 214-44-4263

6. SEX: 1 ☐ M 2 ☒ F

8. AGE (In yrs. last birthday): 46 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 11/28/42 — 11-28-42

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): CARROLL. Co. General. Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Westminster

9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: md

10b. COUNTY: CARROLL

10c. CITY, TOWN OR LOCATION: Sykesville

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 424 Ross Drive

10f. ZIP CODE: 21784

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 2

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TELLER

16b. KIND OF BUSINESS/INDUSTRY: CREDIT UNION

17. FATHER'S NAME (First, Middle, Last): PHILIP KAHMER

18. MOTHER'S NAME (First, Middle, Maiden Surname): LUCILLE COONEY

19a. INFORMANT'S NAME (Type/Print): WALTER JAMES FOWLER

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 424 ROSS DRIVE, SYKESVILLE, MARYLAND 21784

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EVERGREEN MEMORIAL PARK

20c. LOCATION — City or Town, State: FINKSBURG, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell Witzke

22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES, 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Ca, Breast — 2yr.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John E. Steers MD

29c. LICENSE NUMBER: D09557

29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John E. Steers Suite 102 Billingslea Bldg. Westminster, Md. 21157

31. DATE FILED (Month, Day, Year): NOV 1 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 [illegible] be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

Item4 11-15-89 FilmG657 W.H. Per F/H

89 29563

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HILDA GREEN
2. DATE OF DEATH (Month, Day, Year): 10 28 89
3. TIME OF DEATH: 135 PM
4. SOCIAL SECURITY: 216-20-9748
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-30-12
8. BIRTHPLACE (State or Foreign Country): Balto Md
9a. FACILITY NAME (If not institution, give street and number): Liberty Med Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 740 Poplar Grove St
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): George Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alveta Vessells
19a. INFORMANT'S NAME (Type/Print): Mrs Melba Ellis
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1409 E Eutaw St Balto Md 21217
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Auburn Cem
20c. LOCATION — City or Town, State: Balto Co. Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ
22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home 2224 W. North Ave Balto Md 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest — DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Electro mechanical dissociation — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Acute Anterior Wall MI | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dr' Delo MD House officer
29c. LICENSE NUMBER: D-37984
29d. DATE SIGNED (Month, Day, Year): ▶ 10-28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr Zvi SELA MD Liberty medical Center 2600 Liberty Heights

31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

ITEM #10g FILM #G657 PER: F. H. 11/06/89 J. A.

89 29564

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edmund Gumpert
2. DATE OF DEATH: MONTH 10 DAY 28 YEAR 89
3. TIME OF DEATH: 12 45 M
4. SOCIAL SECURITY NUMBER: 213-90-8306
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/3/05
8. BIRTHPLACE (State or Foreign Country): GERMANY
9a. FACILITY NAME (If not institution, give street and number): MILFORD MANOR NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: PIKESVILLE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [X] NO
10e. STREET AND NUMBER: 3004 LIGHTFOOT DR.
10f. ZIP CODE: 21208
10g. CITIZEN OF WHAT COUNTRY? ~~USA~~ GERMANY
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PROPRIETOR
16b. KIND OF BUSINESS/INDUSTRY: KNITTING MACHINES
17. FATHER'S NAME (First, Middle, Last): JOSEF GUMPERT
18. MOTHER'S NAME (First, Middle, Maiden Surname): YETTA BLUMENTHAL
19a. INFORMANT'S NAME (Type/Print): MRS. ANITA D. KLAINBAUM
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3004 LIGHTFOOT DR. BALTIMORE, MD. (21208)
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHEVRA AHAVAS CHESED CEMETERY
20c. LOCATION — City or Town, State: RANDALLSTOWN, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sydney L. Stillman
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD(21215)

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardio pulmon arrest | 7 mins |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Severe organic Brain Syndrome. | 20 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Intercurrent infections

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Samuel L. Berens MD
29c. LICENSE NUMBER: D16941
29d. DATE SIGNED (Month, Day, Year): 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 11 Gladtree Bull md 21208
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 2956

Item:7 per FH G-657
11-1-89 cm

89 29565

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT GRANDSTAFF Robert E. Grandstaff | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 1989 | 3. TIME OF DEATH: 3.50 PM |
| 4. SOCIAL SECURITY NUMBER: 214161124 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-26-~~89~~21 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ==== |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5204 Patrick Henry Drive | 10f. ZIP CODE: 21225 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: World War II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Service Man | 16b. KIND OF BUSINESS/INDUSTRY: Home Heating | |
| 17. FATHER'S NAME (First, Middle, Last): Emanuel G. Grandstaff | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Marcia E. Hansbrough | | |
| 19a. INFORMANT'S NAME (Type/Print): Ethel A. Grandstaff | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5204 Patrick Henry Drive Baltimore, Maryland 21225 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mark's Episcopal Church Cem | 20c. LOCATION — City or Town, State: Boonsboro, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard E Davis | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Maryland 21225 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or haart feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Respiratory failure & Circulatory Shock.
DUE TO (OR AS A CONSEQUENCE OF):
b. T-E Fistula
DUE TO (OR AS A CONSEQUENCE OF):
c. Carcinoma of esophagus.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significent conditions contributing to death but not reeulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☑ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Intern (Medicine) | | ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SYED M.A. RIAZ 1301 LINCOLN WOODS DR. BALTIMORE 21228

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julie Davidson Randall |

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29566

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PATRICIA J. GINSBERG | | | | 2. DATE OF DEATH (Month, Day, Year): 10 30 89 | 3. TIME OF DEATH: 7 40 P M |
| 4. SOCIAL SECURITY NUMBER: 219-38-6892 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 48 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JULY 18, 1941 | 8. BIRTHPLACE (State or Foreign Country): VIRGINIA |
| 9a. FACILITY NAME (If not institution, give street and number): 9129 FLAMEPOOL WAY | | | 9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA | | 9c. COUNTY OF DEATH: HOWARD |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: COLUMBIA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 9129 FLAMEPOOL WAY | | 10f. ZIP CODE: 21045 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALES REPRESENTATIVE | 16b. KIND OF BUSINESS/INDUSTRY: T.R.W. CREDIT CORP. | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES SKEEN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): GRACE BUCHANAN | |
| 19a. INFORMANT'S NAME (Type/Print): DEANNA VOISINE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9129 FLAMEPOOL WAY COLUMBIA, MD 21045 | |
| 20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE CEMETERY | 20c. LOCATION — City or Town, State: DORSEY, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Linda R. Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEROY M & RUSSELL C WITZKE FUNERAL HOME 5555 TWIN KNOLLS ROAD COLUMBIA, MD 21045 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pancreatic Adenocarcinoma- metastatic | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia, Interstitial lung Disease. Anorexia-Cachexia Syndrome Ascites.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John K. Mumford MD | 29c. LICENSE NUMBER: D 30573 | 29d. DATE SIGNED (Month, Day, Year): 10-31-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2 Knott North, Columbia MD 21045 | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2956

89 29567

1.- FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CONLEY CLINE HOOVER | | 2. DATE OF DEATH (Month, Day, Year): 10-7-89 | 3. TIME OF DEATH: 1:42AM M |
| 4. SOCIAL SECURITY NUMBER: 228-38-3952 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 55 ~~54~~ YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01/15/34 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): SBL 301, FRONT OF ALL AMERICAN FORD | 9b. CITY, TOWN OR LOCATION OF DEATH: WALDORF | 9c. COUNTY OF DEATH: CHARLES COUNTY | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Texas | 10b. COUNTY: Harris | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2603 E. Thomas | | 10f. ZIP CODE: 77506 | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korea | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Boiler maker | 16b. KIND OF BUSINESS/INDUSTRY: construction | |
| 17. FATHER'S NAME (First, Middle, Last): Lee Hoover | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne Jones | |
| 19a. INFORMANT'S NAME (Type/Print): Miss Mary Ann Hoover | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 McGrady Squaire Catonsville, Maryland 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Grandview Cemetery | 20c. LOCATION — City or Town, State: Pasadena, Texas | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, Md. 21227 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MULTIPLE INJURIES | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX [X] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence XXX 6 [X] Other (Specify) SCENE | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural XXX 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10-7-89 | 28b. TIME OF INJURY: 1:23AM | 28c. INJURY AT WORK? 1 [ ] YES 2 [XX] NO |
| 28d. DESCRIBE HOW INJURY OCCURED: PEDESTRIAN STRUCK BY AUTO (s) | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): STREET | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): RT. 301, WALDORF, CHARLES CO. MARYLAND | | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 10-7-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JULIA C. GOODIN, MD 111 PENN STREET, BALTIMORE, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): OCT 12 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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Item 7 11-2-89 film G657 LH

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| N Annie Elizabeth HUGHES | | | November 1, 1989 | 4:17 a M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
| 214-18-1176 | 1 ☐ M 2 ☑ F | 91 YRS. | | Oct. 16, 1898 | BALTIMORE |
| 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | 9c. COUNTY OF DEATH |
| FRANKLIN SQUARE HOSPITAL | | ROSEDALE | | Baltimore County |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | BALTIMORE | ROSEDALE | 1 ☐ YES 2 ☑ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1226 HILLDALE RD. | 21237 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☑ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4 or 5 +) | | |
| 6 | | HOMEMAKER | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| ANDREW SANFT | PHILOMENA SCHINATA |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| IONA KELLNER | 1226 HILLDALE RD., BALTIMORE, MD. 21237 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | OAK LAWN CEMETERY | BALTIMORE, MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Denise S. Fox Randall | CVACH/ROSEDALE F.H. INC. 1211 CHESACO AVE., BALTO., MD. 21237 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive heart failure; Bilateral effusion | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| M.D. | | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JEFF HERSHKOWITZ 7000 Franklin Sq Drive, Baltimore, Md 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29568

89 29569

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willis Harrell
2. DATE OF DEATH — MONTH: 10 DAY: 28 YEAR: 89
3. TIME OF DEATH: 1135 AM
4. SOCIAL SECURITY NUMBER: 214-01-5373
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 19, 1904
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1029 Cathedral Street Apt. 7K
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Custodian
16b. KIND OF BUSINESS/INDUSTRY: Balto. Gas & Electric Co.
17. FATHER'S NAME (First, Middle, Last): Unknown
16. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): Katherine G. Sharpe
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1027 Cathdral Street Apt. 7K Balto., MD 21201
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest R Terry, Jr.
22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore Maryland 21216

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Fail
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Renal Fail.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sabah Al-Attar, M.D.
29c. LICENSE NUMBER: D37725
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sabah AL-Attar, M.D., Liberty Medical Ctr., Baltimore, MD
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29570

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Ira Haygooni | | 10 27 89 | 10:05 M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 137-12-3398 | 1 ☐ M 2 ☒ F | 89 YRS. | | | APR.6,1900 | NEW YORK |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| MEDIDIAN HOMEWOOD N.H. | BALTIMORE CITY | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | | BALTIMORE CITY | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 300 E.UNIVERSITY PKWY | 21218 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 2 | SALES | RETAIL SALES |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| NISHAN HAYGOONI | ZAROOHI N/A |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DOROTHY T. RODGERS | 27 PARLIAMENT CT. BALTIMORE MD. 21212 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | GRACE LAWN MEM.PARK | NEW CASTLE DEL. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ R.A. Ruth | 4905 YORK RD. H.W.JENKINS AND SONS CO. BALTO.MD.21212 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASCVD with CVA and | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. left hemiparesis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Multiple infarct Dementia | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D02180 | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ingeborg Fromm M.D. 8014 Old Harford Rd.,Balto.,Md.21214

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | [signature] |

DHMH-16 Rev 1/89

89 29571

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2, 3-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRIETT E HINES
2. DATE OF DEATH — MONTH: 10 DAY: 30 YEAR: 89
3. TIME OF DEATH: 11:20 PM
4. SOCIAL SECURITY NUMBER: 220-125-119
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/13/06
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): HHC Harbor Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MD.
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: GLENBURNIE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6656 ROBERTS CT. GLENBURNIE APT 96
10f. ZIP CODE: MD 21061
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unemployed
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Frank HANKINS
18. MOTHER'S NAME (First, Middle, Maiden Surname): BROADWATER EMMA
19a. INFORMANT'S NAME (Type/Print): Howard Hines JR
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4811 Pimlico Rd. Balto md 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cem.
20c. LOCATION — City or Town, State: Balto County
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wesley Elmore
22. NAME AND ADDRESS OF FACILITY: Wm. J. Marche Funeral Home 4300 Wabash Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. MIEAF
DUE TO (OR AS A CONSEQUENCE OF):
c. Arteriosclerotic Vascular disease.
DUE TO (OR AS A CONSEQUENCE OF):
d. Anemia Sickell Phenomena

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
COPD
IDDM

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Inder M Johan Singh Luthra
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): INDER MOHAN SINGH LUTHRA HHC 3001 S. HANOVER ST. BALTIMORE MD 21230
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Linda Davidson-Randall

DHMH-16 Rev 1/89

89 29572

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 4:55 A.M.

12

1. DECEDENT'S NAME (First, Middle, Last): PEARL W. HIGGER — PEARL W. HIGGER

2. DATE OF DEATH: MONTH 10 DAY 28 YEAR 89

3. TIME OF DEATH: 4:55 AM

4. SOCIAL SECURITY NUMBER: 216-07-2250 / 216072250

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 12/31/09

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): UMMS

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MD

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2835 MARNAT ROAD, APT. A

10f. ZIP CODE: 21209

10g. CITIZEN OF WHAT COUNTRY?: usa

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALESLADY

16b. KIND OF BUSINESS/INDUSTRY: HESS SHOE CO.

17. FATHER'S NAME (First, Middle, Last): JOSEPH WEISBLATT

18. MOTHER'S NAME (First, Middle, Maiden Surname): ESTHER ROSE SEMKER

19a. INFORMANT'S NAME (Type/Print): MR. JOSEPH GOLDBERG

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3804 VICTORIA AVE. BALTIMORE, MD 21207

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH TFILOH CONG.

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE:

22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | PURULENT PERICARDITIS / MEDIASTINITIS | 36 HRS. |
| DUE TO (OR AS A CONSEQUENCE OF): b. | S/P CABG / Hx ISCHEMIC HEART DISEASE | 5 wks. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | ACUTE AND CHRONIC RENAL FAILURE | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PVD
HTN

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jeremy Steinbaum MD (Resident Thoracic Surgery)

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): 10/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JEREMY STEINBAUM, UMMS, 21 S. GREENE ST. BALT, MD 21201

31. DATE FILED (Month, Day, Year): NOV 1 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 2952

NOV 1 1989

89 29573

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna D. Hammer
2. DATE OF DEATH: MONTH 10 DAY 27 YEAR 89
3. TIME OF DEATH: 7:30 AM
4. SOCIAL SECURITY NUMBER: 213092667
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 95 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): AUG. 29, 1894
8. BIRTHPLACE (State or Foreign Country): BALTO. MD.
9a. FACILITY NAME (If not institution, give street and number): GOOD SAMARITAN HOSP.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTO. CITY
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 2108 HAMILTON AVE
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — ~~American Indian, Black~~, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): FREDERICK DORSCH
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH BECKER
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MORELAND MEM. PARK
20c. LOCATION — City or Town, State: PARKVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jeffrey L. Gair
22. NAME AND ADDRESS OF FACILITY: EVANS FUNERAL CHAPEL

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. sepsis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. intraabdominal injection
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
colon cancer
anemia
congestive heart failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Samer Dibs, M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 10/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samer Dibs, M.D.
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29574

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM HENRY JOHNSON JR. | | | 2. DATE OF DEATH (Month, Day, Year): 10 27 1989 | 3. TIME OF DEATH: 4 15 P.M. |
| 4. SOCIAL SECURITY NUMBER: 213-30-7330 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 6 1936 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 4739 BONNIE BRAE RD | | 9b. CITY, TOWN OR LOCATION OF DEATH: PIKESVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: PIKESVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4739 BONNIE BRAE RD | | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): & College | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sr. Juvenile Counselor | 16b. KIND OF BUSINESS/INDUSTRY: State of Maryland Waxter Children's Center | |
| 17. FATHER'S NAME (First, Middle, Last): William Henry Johnson Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Tessie Fedd | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Estelle R. Johnson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4739 Bonnie Brae Rd. Pikesville, Balto. Co., MD. 21208 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ernest R. Perry, Jr. | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, MD 21216 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | Immediate |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [✓] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Deputy Medical Examiner | 29c. LICENSE NUMBER: D01085 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY Z. Felsenberg MD. 11 E. Chase St 21202

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29575

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): EVELYN JOHNSON
2. DATE OF DEATH (Month, Day, Year): 10 24 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11 6 19
8. BIRTHPLACE (State or Foreign Country): NORTH CARALINA
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2132 ASHBURTON STREET
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY: US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES:
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): CLARENCE BARNES
18. MOTHER'S NAME (First, Middle, Maiden Surname): MAGGIE MOORE
19a. INFORMANT'S NAME (Type/Print): MELVIN JOHNSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3031 GLENN AVE BALTIMORE 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DEER PARK
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] #2281
22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721-27 MONROE ST. 21217

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Vascular Disease | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Hypertension | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D00359
29d. DATE SIGNED (Month, Day, Year): 10/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. C. ALEVIZATOS, M.D. 301 ST. PAUL PLACE 21202
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89 25215

NOV 1 1989

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Girl Jones — BABY GIRL JONES
2. DATE OF DEATH (Month, Day, Year): 9 / 6 / 89
3. TIME OF DEATH: 6:45 P M
4. SOCIAL SECURITY NUMBER: N/A
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): New born YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS 0 MIN. 45
7. DATE OF BIRTH (Month, Day, Year): 9/6/89
8. BIRTHPLACE (State or Foreign Country): Baltimore, MD
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital, Baltimore
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: U.S.A.

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO: X
10e. STREET AND NUMBER: 2915 DENISAM CIRCLE
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc.: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): N/A — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A
16b. KIND OF BUSINESS/INDUSTRY: N/A

17. FATHER'S NAME (First, Middle, Last):
18. MOTHER'S NAME (First, Middle, Maiden Surname): WANDA D. JONES

19a. INFORMANT'S NAME (Type/Print): WANDA D. JONES
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2915 DENISAM CIRCLE, BALTIMORE, MD. 21225

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Witzke
22. NAME AND ADDRESS OF FACILITY: Witzke Funeral Home 1630 Edmondson Ave. Baltimore, Maryland 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Extreme prematurity | 45 min |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: S. Sreedhar MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 9/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SUBHA SREEDHAR 8606. OPEN MEADOW WAY COLUMBIA MD. 21045.
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

9

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| PAULSON, MARY JANE | | | 10 28 1989 | 07:41 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 356-24-2606 | 1 ☐ M 2 ☒ F | 56 YRS. | | | June, 2, 1933 | Illinois |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Harford | Bel Air | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 819 Moores Mill Rd. | 21014 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO | white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 yrs | 6 Yrs. | Social worker | Adult Day Care Center |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Herbert Petersen | Mildred Gardner |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mr. Edwin Paulson | 819 Moores Mill Rd. Bel Air, Md. 21014 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Metro Crematory | Balto.Md.21229 |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ E. F. Lassahn | E.F.Lassahn Funeral home 11750 Belair Rd. Kingsville, Md. 21087 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pulmonary embolus DUE TO (OR AS A CONSEQUENCE OF): | 1 hr |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. | Acute Myelogenous Leukemia DUE TO (OR AS A CONSEQUENCE OF): | 14 mo. |
| c. | DUE TO (OR AS A CONSEQUENCE OF): | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | F0002 | ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Timothy J. Ramp

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | [signature] |

OHMH-16 Rev 1/89

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

9

89 29578

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CATHERINE F. KANE | | | 2. DATE OF DEATH (Month, Day, Year): OCT. 30, 1989 | 3. TIME OF DEATH: 1:40 PM |
| 4. SOCIAL SECURITY NUMBER: 217-56-5436 | 5. SEX: 1 ☐ M 2 ☐ F XX | 6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): AUG. 8, 1905 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): COLLEGE MANOR | | 9b. CITY, TOWN OR LOCATION OF DEATH: LUTHERVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: TOWSON | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO XX |
| 10e. STREET AND NUMBER: 204 E. JOPPA RD. | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): HENRY FELDPUSCH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIE KAISER | |
| 19a. INFORMANT'S NAME (Type/Print): W. JEROME TABELING | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 204 E. JOPPA RD. TOWSON MD. 21204 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE MAUS. | 20c. LOCATION — City or Town, State: WOODLAWN MD. 21207 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edison M. Perkins Jr. | | 22. NAME AND ADDRESS OF FACILITY: H.W. JENKINS AND SONS CO. 4905 YORK RD. BALTO. MD. 21212 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Poor nutrition, Advanced Age | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Recent pneumonia; Dementia, Atrial Fibrillation

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: E. Timothy Souweine | 29c. LICENSE NUMBER: 02732 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. TIMOTHY SOUWEINE 1134 YORK RD. Lutherville, Md. | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 29579

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Andrew | | Keene | 10 / 28 / 89 | 7:10 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-38-5111 | 1 [X] M 2 [ ] F | 48 YRS. | | | 6-29-41 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 432 e. 22nd Street | Baltimore | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 432 EAST 22nd STREET | 21218 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th Grade | | CUSTODIAN | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| FREDERICK KEENE | MYRTLE JONES |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MYRTLE KEENE BOND | 432 EAST 22nd STREET/BALTIMORE, MD 21218 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | BALTIMORE CEMETERY | BALTIMORE, MD 21202 |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Francis [illegible] | W.C. MARCH F.H. 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease and Chronic alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |
| HEAD ONLY | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29580

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Catherine Keene
2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89
3. TIME OF DEATH: 0605A M
4. SOCIAL SECURITY NUMBER: 216-10-3704D
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 94 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 6, 1895
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2902 Grindon Ave.
10f. ZIP CODE: 21214
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John Trageser
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Rennerd
19a. INFORMANT'S NAME (Type/Print): Margaret H. Keene
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2902 Grindon Ave., Baltimore, MD 21214
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DulaneyValley Memorial Gardens
20c. LOCATION — City or Town, State: Timonium, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Glenn Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. dehydration | 2 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J. Thomas MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10 30 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Thomas MD 2201 University Pkwy Balto MD 21218
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29581

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

3

**1. DECEDENT'S NAME** (First, Middle, Last): CELIE KLIOZE

**2. DATE OF DEATH** (Month, Day, Year): OCT. 29, 1989

**3. TIME OF DEATH**: 5:10 A M

**4. SOCIAL SECURITY NUMBER**: 213-34-2632

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 91 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 1/15/98

**8. BIRTHPLACE** (State or Foreign Country): ROUMANIA

**9a. FACILITY NAME** (If not institution, give street and number): JEWISH CONVALESCENT HOME

**9b. CITY, TOWN OR LOCATION OF DEATH**: PIKESVILLE

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: BALTIMORE

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 3815 MENLO DR.

**10f. ZIP CODE**: 21215

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE

**16b. KIND OF BUSINESS/INDUSTRY**: HOMEMAKER

**17. FATHER'S NAME** (First, Middle, Last): LOUIS GREENBERG

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): PAULINE UNKNOWN

**19a. INFORMANT'S NAME** (Type/Print): IRVIN KLIOZE

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3815 MENLO DR. BALTIMORE, MD. ( 21215)

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): WORKMENS CIRCLE

**20c. LOCATION — City or Town, State**: BALTIMORE, MD.

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Sydney L. Stellman

**22. NAME AND ADDRESS OF FACILITY**: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD (21215)

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Final disease or condition resulting in death)** → a. MYOCARDIAL INFARCTION (probable)

DUE TO (OR AS A CONSEQUENCE OF):

**Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Atherosclerotic Heart Disease

Previous Cerebral Infarction

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY**

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: MD

**29c. LICENSE NUMBER**: D15140

**29d. DATE SIGNED** (Month, Day, Year): ▶ 10/30/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): I.M. SUNSHINE MD 6310 PK HTS Ave, Balto MD. 21215

**31. DATE FILED** (Month, Day, Year): NOV 1 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

89 29581

NOV 1 1989

89 29582

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH W. KENNEDY, SR. | | 2. DATE OF DEATH (Month, Day, Year): 10/28/89 | 3. TIME OF DEATH: 12:13 Noon |
| 4. SOCIAL SECURITY NUMBER: 215-20-5697 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 13, 1923 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: -- | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 1302 DENBRIGHT ROAD | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc.: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERINTENDENT | 16b. KIND OF BUSINESS/INDUSTRY: U.S.F.& G. INSURANCE |
| 17. FATHER'S NAME (First, Middle, Last): CLARENCE MATHAIS KENNEDY | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FLORENCE AGNES POWERS | |
| 19a. INFORMANT'S NAME (Type/Print): SHIRLEY KENNEDY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1302 DENBRIGHT ROAD, CATONSVILLE, MARYLAND 21228 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify): | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VETERANS CEMETERY | 20c. LOCATION — City or Town, State: OWINGS MILLS, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. lung Ca (Non small) DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: diverticulosis

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Y. Monla MD. ST. AGNES HOSPITAL, BALTIMORE, MD. | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

Item:18 per FH G-657
11-24-89 cm

89 29583

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY S. KUEBERTH
2. DATE OF DEATH (Month, Day, Year): OCT. 26, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216-52-6973
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Nov. 8, 1895
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN-PERRING PKWY.
9b. CITY, TOWN OR LOCATION OF DEATH: PARKVILLE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: BALTO. CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5721 WILLOWTON AVE
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AT HOME
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): MICHAEL SCHAEFER
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary M Albert ~~ELIZABETH PLANTHOLT~~
19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER
20c. LOCATION — City or Town, State: BALTO. MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald R. Sandy
22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PARKINSON DISEASE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Intermediate cardiovascular disease
Virus infection

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R. Donald Sandy
29c. LICENSE NUMBER: D 5820
29d. DATE SIGNED (Month, Day, Year): ▶ 10-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. DONALD R. SANDORF 7463 HARFORD ROAD
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

89 29584

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH HAZEL LAMOREAUX | | | 2. DATE OF DEATH (Month, Day, Year): 10 29 89 | 3. TIME OF DEATH: 0535 AM |
| 4. SOCIAL SECURITY NUMBER: 212-20-7972 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-25-25 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 105 Mark Drive | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): (Assembler) | 16b. KIND OF BUSINESS/INDUSTRY: Gould Electronics | |
| 17. FATHER'S NAME (First, Middle, Last): William Kearney | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth McMahon | |
| 19a. INFORMANT'S NAME (Type/Print): Nathan Lamoreaux | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 Mark Drive Glen Burnie, Maryland 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeone Gonce | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiorespiratory arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiogenic Shock | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Congestive Heart failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

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|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D 23624 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. BASANT K. KHANDELWAL, M.D. 7422 BALTO-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29585

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIE MINTIENS | | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 29 / 89 | 3. TIME OF DEATH: 7:35 PM |
| 4. SOCIAL SECURITY NUMBER: 213-14 9439 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-17-07 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): STELLA MARIS HOSPICE | | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: = | 10c. CITY, TOWN OR LOCATION: Balto. | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2807 Baurenwood Ave. | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retail Sales Tax | 16b. KIND OF BUSINESS/INDUSTRY: State of Md. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): John Luckhardt | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Kathy Renner |
| 19a. INFORMANT'S NAME (Type/Print): John G. Mintiens | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1916 Edgewood Rd. Balto., Md. 21234 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cem. | 20c. LOCATION — City or Town, State: BAlto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: John C. Miller Inc. 6415 Belair Rd. BAlto., Md, 21206 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC COLON CANCER | 5 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER 19406 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ed NAKHUda - Stella Maris Dulaney Valley Rd.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 31 1989 | 32. REGISTRAR'S SIGNATURE: Gene Carlson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29586

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Andrew Martin | | | 2. DATE OF DEATH (Month, Day, Year): 9-13-89 | 3. TIME OF DEATH: 3:47p M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday) YRS. / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring | | 9c. COUNTY OF DEATH: Montgomery Co. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 101 WILLIAMSBURG DR. | | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | |
| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald D White 10.31.89 | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cranio-cerebral Trauma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) 9-13-89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject precipated down steps. |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 101 Williamsburg Dr. Silver Spring, MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Ann M. Dixon, M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-14-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, M.D. 101 Penn St. Baltimore, MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Pendleton |

DHMH-16 Rev 1/89

89 29587

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harvey MILES
2. DATE OF DEATH (Month, Day, Year): October 26, 1989
3. TIME OF DEATH: 4:57 PM
4. SOCIAL SECURITY NUMBER: 218-03-1146
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 5-2-16
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8 Breaker Ct.
10f. ZIP CODE: 21221
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSTRUCTION
16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): James Miles
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mozella Carter
19a. INFORMANT'S NAME (Type/Print): Doretta Miles
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8 Breaker Ct. Balto., Md. 21221
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hills Mem.
20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W Hall Brawner
22. NAME AND ADDRESS OF FACILITY: Wm C. Brawner F.H. 1206 W. North Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):
b. METASTATIC [redacted] LUNG CANCER
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D29071
29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KRISHNAN, MD 821 N EUTAW ST #308 BALTIMORE 21201
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Registrar

DHMH-18 Rev 1/89

89 29588

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Helen Watts Miller | | | 2. DATE OF DEATH (Month, Day, Year): 10/31/89 | 3. TIME OF DEATH: 10:30 AM |
| 4. SOCIAL SECURITY NUMBER: 216-46-5078 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11/23/09 | 8. BIRTHPLACE (State or Foreign Country): Baltimore |
| 9a. FACILITY NAME (If not institution, give street and number): 5616 St. Albans Way | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5616 St. Albans Way | | 10f. ZIP CODE: 21212 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Christopher C. Watts | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Schultz | | |
| 19a. INFORMANT'S NAME (Type/Print): H. Ellsworth Miller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5616 St. Albans Way Balto. Md. 21212 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John a Slade | 22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins Funeral Home 4905 York Rd. Balto. Md. 21212 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. LUNG CANCER | 18 mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul O Symm | 29c. LICENSE NUMBER: D10670 | 29d. DATE SIGNED (Month, Day, Year): ~~10~~ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. SAPIR MD 9 E. CHASE ST. BALTO.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29589

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

6

**1. DECEDENT'S NAME** (First, Middle, Last): VERNON LEROY MISKIMON, SR.

**2. DATE OF DEATH** (Month, Day, Year): 10 27 89

**3. TIME OF DEATH**: 1045 PM

**4. SOCIAL SECURITY NUMBER**: 220-03-4255

**5. SEX**: 1 ☒ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 72 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): MAY 8, 1917

**8. BIRTHPLACE** (State or Foreign Country): MARYLAND

**9a. FACILITY NAME** (If not institution, give street and number): FRANCIS SCOTT KEY MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MARYLAND

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**: EASTWOOD

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 532 S. 45TH STREET

**10f. ZIP CODE**: 21224

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)

Elementary/Secondary (0-12): 8TH GRADE

College (1-4 or 5+): N/A

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYEED

**16b. KIND OF BUSINESS/INDUSTRY**: Vernon L. Miskimon & Sons Plum. & Heating, Inc.

**17. FATHER'S NAME** (First, Middle, Last): LEO F. MISKIMON

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): NAHOMI M. ROBINSON

**19a. INFORMANT'S NAME** (Type/Print): CLARA M. MISKIMON

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 532 S. 45TH STREET BALTIMORE, MARYLAND 21224

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 10-31-1989

**20c. LOCATION — City or Town, State**: BALTIMORE, MARYLAND

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Scott P. Gardner

**22. NAME AND ADDRESS OF FACILITY**: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Prostate Cancer | 4 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)

HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**:

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: John K. Burgers MD

**29c. LICENSE NUMBER**: D35566

**29d. DATE SIGNED** (Month, Day, Year): 10/27/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): JOHN K. BURGERS, 4940 Eastern Ave., BALTO., MD 21236

**31. DATE FILED** (Month, Day, Year): NOV 1 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29590

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RUTH MOSKOVITZ | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 1989 | 3. TIME OF DEATH: 5:55 P. M |
| 4. SOCIAL SECURITY NUMBER: 196-32-3550 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-16-1914 | 8. BIRTHPLACE (State or Foreign Country): PA. |
| 9a. FACILITY NAME (If not institution, give street and number): 2811 NAVARRE DRIVE | | 9b. CITY, TOWN OR LOCATION OF DEATH: CHEVY CHASE | 9c. COUNTY OF DEATH: MONTGOMERY | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: CHEVY CHASE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 2811 NAVARRE DRIVE | | 10f. ZIP CODE: 20815 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES XX | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COMPUTER ANALYST | 16b. KIND OF BUSINESS/INDUSTRY: DEPT. OF TREASURY | |
| 17. FATHER'S NAME (First, Middle, Last): MAX L. MOSKOVITZ | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DENA BALDINGER | | |
| 19a. INFORMANT'S NAME (Type/Print): ETHEL MEYER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2811 NAVARRE DR. CHEVY CHASE, MD. 20815 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DICKSON CITY CEMETERY | 20c. LOCATION — City or Town, State: DICKSON CITY, PA. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Andrew Duvall | | 22. NAME AND ADDRESS OF FACILITY: IVES-PEARSON FUNERAL HOMES 2847 WILSON BLVD. ARLINGTON, VA. 22201 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ovarian Ca | 7/86 3yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 6 ☒ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Kathryn S. Kunin MD | D26992 | ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 10400 Connecticut Ave. Suite 606 Kensington, MD 20895

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Kennedy |

DHMH-16 Rev 1/89

89 29591

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MATTHEW MARCUS
2. DATE OF DEATH: MONTH 10 DAY 26 YEAR 89
3. TIME OF DEATH: 6 25 A M
4. SOCIAL SECURITY NUMBER: 219-32-5040
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/9/04
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSP
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTO.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 36 N. KOSSUTH ST
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+): College
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MINISTER
16b. KIND OF BUSINESS/INDUSTRY: LITTLE ARK BAPT. CHURCH
17. FATHER'S NAME (First, Middle, Last): HENRY CLAY MARCUS
18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA SYKES
19a. INFORMANT'S NAME (Type/Print): AMANDA MARCUS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36 N. KOSSUTH ST BALTO. MD. 21229
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DRUID RIDGE CEM
20c. LOCATION — City or Town, State: REISTERSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph B. Locke
22. NAME AND ADDRESS OF FACILITY: Locke Funeral Home 1304 N. Central Ave

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA - SEPSIS
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ~~RESPIRATION~~ RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. CARDIAC FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
d. ASPIRATION

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: H. Ghazal House Officer
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 10/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HASSAN GHAZAL; ~~Sinai~~ Sinai Hosp. of Baltimore
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29592

Item #6 per FH 11/3/89 sp

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES MOBLEY JR. | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 30 / 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 219-38-8723 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 48 ~~49~~ YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-14-41 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER LAUREL BELTSVILLE HOSP. | | 9b. CITY, TOWN OR LOCATION OF DEATH: LAUREL, MD | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: LAUREL | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER: 8804 HUNTING LANE APT. 1 | | 10f. ZIP CODE: 20819 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 ND Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EMPLOYEE @ FORT MEADE | | 16b. KIND OF BUSINESS/INDUSTRY: NA |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES MOBLEY SR. | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MAGGIE MILLER MOBLEY | |
| 19a. INFORMANT'S NAME (Type/Print): MAGGIE MOBLEY | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2422 E. HOFFMAN STREET/BALTIMORE, MD 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRISON FOREST VET. CEMETERY | 20c. LOCATION — City or Town, State: OWINGS MILLS, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John B. Johnson Jr. | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F.H. 1101 E. NORTH AVENUE 21202 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sudden death, etiology unknown | unknown |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Hypertension, left ventricular dysfunction | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Status post abdominal surgery (10/25/89)

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 ND | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | |
| 27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 8 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 YES 2 NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD 11/2/89 | 29c. LICENSE NUMBER: D17638 | 29d. DATE SIGNED (Month, Day, Year): 10/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TRISTAN J. ORELLANO MD | 14201 Laurel Park Dr #104 Laurel MD 20707 | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

09 2952

89 29593

1 - FOR STATE REGISTRAR RICHARD W. MANN

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Richard W. Mann | | | 2. DATE OF DEATH (Month, Day, Year): 10/30/89 | 3. TIME OF DEATH: 8:25 AM |
| 4. SOCIAL SECURITY NUMBER: 578-34-3693 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): MAY 5, 1929 | 8. BIRTHPLACE (State or Foreign Country): WASHINGTON, D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA | | 9c. COUNTY OF DEATH: HOWARD |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: COLUMBIA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 7080 CRADLE ROCK WAY | | 10f. ZIP CODE: 21045 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHEF | 16b. KIND OF BUSINESS/INDUSTRY: FOOD | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES R. MANN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISE G. FRENZELL | |
| 19a. INFORMANT'S NAME (Type/Print): IDA MAE MANN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7080 CRADLE ROCK WAY, COLUMBIA, MD. 21045 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY | 20c. LOCATION — City or Town, State: CATONSVILLE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MARYLAND 21045 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiogenic shock + respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. massive myocardial infarction with extension | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. pneumonia + sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. gastrointestinal bleeding 2° to ischemic bowel | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D26624 | 29d. DATE SIGNED (Month, Day, Year): 11/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3400 Ellicott Center Drive, Ellicott City MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29594

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) CARLTON Allen MATRAU Carlton Allen Matrau | | 2. DATE OF DEATH (Month, Day, Year) 10 28 89 | 3. TIME OF DEATH 1105 AM |
| 4. SOCIAL SECURITY NUMBER 218-70-2445 | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 34 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year) 07-01-55 | 8. BIRTHPLACE (State or Foreign Country) Massachusetts | | |
| 9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | 9c. COUNTY OF DEATH ----- | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE MD | 10b. COUNTY ----- | 10c. CITY, TOWN OR LOCATION Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER 360 Marydell Road | 10f. ZIP CODE 21229 | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Commercial Artist | 16b. KIND OF BUSINESS/INDUSTRY Design Studio | |
| 17. FATHER'S NAME (First, Middle, Last) John W. Matrau | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida M. Downs | | |
| 19a. INFORMANT'S NAME (Type/Print) Dorothy G. Matrau | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 360 Marydell Road, Balto., MD 21229 | | |
| 20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park | 20c. LOCATION — City or Town, State Glen Burnie, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb | 22. NAME AND ADDRESS OF FACILITY 301 Frederick Road Catonsville, Maryland 21228 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Coronary Atherosclerosis | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic Renal Failure | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabetes Mellitus | Years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Bert F. Morton, M.D. | D08949 | ▶ 10/28/86 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BERT F. MORTON, M.D. - ST. AGNES HOSPITAL - 900 CATON AVENUE, 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 2529

NOV 1 1989

89 29595

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

10

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| FRANCES FAUNTLEROY | OGLESBY | | 10 27 1989 | 12:50 A. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-20-4077 | 1 ☐ M 2 ☒ F | 74 YRS. | | | 02/13/1915 | VIRGINIA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| G.B.M.C.-6701 N. CHARLES ST | BALTIMORE, MD | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE CITY | BALTIMORE, MARYLAND | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 119 N. CULVER STREET | 21229 | |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Self Employed | Caterer |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| FREDDIE WILLIAMS | SARAH FAUNTLEROY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Polie C. Oglesby | 119 North Culver Street Baltimore, Maryland 21229 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Garrison Forest Veteran Cem. | Balto. County, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Gary L. Rollens | Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIORESPIRATORY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. RENAL FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. TERMINAL OVARIAN CANCER | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Richard [illegible] MD | | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RICHARD TAAVON-6701 N. CHARLES ST., BALTIMORE, MD 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

Item 8 11-2-89 film G657 LH

89 29596

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Gertrude, OTTELIA PALIK
2. DATE OF DEATH (Month, Day, Year): 10 27 89
3. TIME OF DEATH: 12 30 AM
4. SOCIAL SECURITY NUMBER: 216-36-9189
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS — DAYS
IF UNDER 24 HRS.: HOURS — MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-22-03
8. BIRTHPLACE (State or Foreign Country): West Germany
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Harford
10c. CITY, TOWN OR LOCATION: Fallston
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2607 Laurel Brook Rd.
10f. ZIP CODE: 21047
10g. CITIZEN OF WHAT COUNTRY?: W. Germany
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES: no
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 yrs
College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home maker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Teophil Muchalla
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Smikalla
19a. INFORMANT'S NAME (Type/Print): Joseph D. Deigert
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O.Box 7, 2605-2607 Laurel Brook Rd. Fallston, Md. 21047
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery
20c. LOCATION — City or Town, State: Parkville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn
22. NAME AND ADDRESS OF FACILITY: E.F. Lassahn Funeral Home, 11750 Belair Rd. Kingsville, Md. 21087

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiovascular | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASVD | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
hyperosmolar diabetic coma
dehydration

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: David S. Dunn D
29c. LICENSE NUMBER: D32299
29d. DATE SIGNED (Month, Day, Year): ▶ 11/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID S. DUNN 1131 Belaire Road
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

8

89 29597

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Item 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DRUCILLA PRATT | | | 2. DATE OF DEATH (Month, Day, Year): 10 26 89 | 3. TIME OF DEATH: 4 25 PM |
| 4. SOCIAL SECURITY NUMBER: 219-32-1600 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 102 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03-17-1887 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTRE | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 501 Dolphin Street Apt. 1111 | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Domestic |
| 17. FATHER'S NAME (First, Middle, Last): James Gray | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eliza Chase | |
| 19a. INFORMANT'S NAME (Type/Print): Victoria N. Turner | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 210 Eastern Ave Annapolis, Maryland 21403 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | 20c. LOCATION — City or Town, State: Baltimore County, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Herbert E. Nutter | | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy. Baltimore, Maryland 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. POSSIBLE ACUTE MYOCARDIAL INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSCLEROTIC HEART DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HAEMATURIA.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD. | D 23300 | ▶ 10·26·89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LIBERTY MEDICAL CENTRE — 2600 Liberty Heights BALTIMORE MD. 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 25597

89 29598

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Catherine Petty
2. DATE OF DEATH (Month, Day, Year): 10 30 89
3. TIME OF DEATH: 10:32 AM
4. SOCIAL SECURITY NUMBER: 220-14-0509
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): 2/19/02
8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Meridian Heritage
RESIDENCE OF DECEDENT
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: Baltimore
10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 135 N. Decker Avenue
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker
15b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): Nicholas Busch
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marguerite Monahan
19a. INFORMANT'S NAME (Type/Print): Edna K. Rejzek
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 135 N. Decker Avenue/Balto. MD 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter D. Rejzek
22. NAME AND ADDRESS OF FACILITY: John A. Moran, Inc. 3000 E. Baltimore St/Balto. MD 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Possible Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Coronary Insufficiency

DUE TO (OR AS A CONSEQUENCE OF):

c. COPD

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A Chatterjee
29c. LICENSE NUMBER: D23530
29d. DATE SIGNED (Month, Day, Year): ▶ 10-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ASHOK K. CHATTERJEE, M.D., P.A. 3927 ANNAPOLIS ROAD BALTIMORE, MD 21227

31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Steve Davidson-Mundell

DHMH-16 Rev 1/89

89 29298

89 29599

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEONARD REESE | | | 2. DATE OF DEATH (Month, Day, Year): 10 27 89 | 3. TIME OF DEATH: 8:15 A-M |
| 4. SOCIAL SECURITY NUMBER: 216-09-2111 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/02/10 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL OF BALTIMORE | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE CO. | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4 AMLEHT CT. | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | |
| 19a. INFORMANT'S NAME (Type/Print): Sheila Reese (spouse) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Amleht Ct., Baltimore, Md. 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald A. Wade 10-31-89 | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | 15 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. OSTEOSARCOMA OF PELVIS | 10 MONTHS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED: — | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): — | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): — | |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MANGESH SHUKLA, M.D RESIDENT | MS-9307 | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MANGESH SHUKLA, SINAI HOSPITAL, BALTIMORE MD 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 10/27/1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-29600

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY GIRL RORIE BABY GIRL RORIE

2. DATE OF DEATH: MONTH 9 DAY 4 YEAR 1989

3. TIME OF DEATH: 1009 P M

4. SOCIAL SECURITY NUMBER: N/A

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 8/31/89

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): ST. AGNES Hospital 900 CATON AVE. BALTIMORE

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: PRINCE GEORGES

10c. CITY, TOWN OR LOCATION: CAPITAL HEIGHT

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 5113 ADDISON ROAD

10f. ZIP CODE: 20743

10g. CITIZEN OF WHAT COUNTRY? U.S.A

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Not Applicable — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None

16b. KIND OF BUSINESS/INDUSTRY: Not Applicable

17. FATHER'S NAME (First, Middle, Last):

18. MOTHER'S NAME (First, Middle, Maiden Surname): DONNICE RORIE

19a. INFORMANT'S NAME (Type/Print): DONNICE RORIE

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5113 ADDISON ROAD, CAPITAL HEIGHTS, MD. 20743

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery

20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: Witzke Funeral Home 1630 Edmondson Ave. Baltimore, Maryland 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PREMATURITY

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. SEVERE HMD

DUE TO (OR AS A CONSEQUENCE OF):

c. RENAL FAILURE

DUE TO (OR AS A CONSEQUENCE OF):

d. CARDIO PULMONARY ARREST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: LYONE M. CITRON MD, M.P.H

29c. LICENSE NUMBER: RESIDENT

29d. DATE SIGNED (Month, Day, Year): 9/4/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ST. AGNES HOSPITAL, BALTIMORE, MD.

31. DATE FILED (Month, Day, Year): NOV 1 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Witzke Funeral Home 1630 Edmondson Ave.
Baltimore, Maryland 21228

New Cathedral Cemetery Baltimore, Maryland

89-29601

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

6

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): JANET P. ROBERTSON | | | | | 2. DATE OF OEATH (Month, Day, Year): October 25, 1989 | 3. TIME OF DEATH: 12:40 P. M |
| 4. SOCIAL SECURITY NUMBER: 212-56-3324 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 40 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6/16/49 | 8. BIRTHPLACE (State or Foreign Country): Baltimore, MD. |
| 9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF OEATH: SALISBURY | | 9c. COUNTY OF DEATH: WICOMICO | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Delaware | 10b. COUNTY: Sussex | | 10c. CITY, TOWN OR LOCATION: Millsboro | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: Box H-3 Pot-Nets North | | | 10f. ZIP CODE: 19966 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. OECEOENT'S EOUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | | | 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | | 16b. KINO OF BUSINESS/INOUSTRY: Super Fresh Super Market | |
| 17. FATHER'S NAME (First, Middle, Last): Harold D. Powell | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Corrine Carew | | | |
| 19a. INFORMANT'S NAME (Type/Print): Richard B. Robertson | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box H-3 Pot-Nets North, Millsboro, DE. 19966 | | | |
| 20a. METHOD OF OISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF OISPOSITION (Name of cemetery, crematory or other place): Cape Henlopen Crematory | | 20c. LOCATION — City or Town, State: Lewes, Delaware 19958 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | | 22. NAME AND ADDRESS OF FACILITY: Melson Funeral Services, Ltd. Millsboro, Delaware 19966 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Large Cell Undifferentiated Carcinoma of Lung | 5 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] J. E. Martin, M.D. | 030690 | ▶ 10/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 145 E. Carroll St., Salisbury, MD. James E. Martin, M.D.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | [signature] Fuller Davidson-Randall |

DHMH-16 Rev 1/89

6

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29602

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Julia | Stubbs | 10-24-89 | 11:11AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-38-5454 | 1 ☐ M 2 ☑ F | 46 YRS. | | | 6-12-43 | MD. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1925 N. Payson | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | | Balto. | 1 ☑ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3018 Harlem Ave | 21216 | U S A |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☑ NO Specify: | Specify: B |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Nurse | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Wesley Dargan Sr. | Susan Hollman |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Susan Stewart | 3018 Harlem Ave Balto., MD. 21216 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Western Star Cemetery | Catonsville, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Wm C. Brown | Wm C. Brown Community F.H. 1206 W. North Ave |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Fatty liver due to chronic alcoholism | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XXX YES 2 ☐ NO | XXX YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XXX YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home XXX Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| XXX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin, MD | OCME | ▶ 10-25-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia C. Goodin, MD 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Ragland |

DHMH-16 Rev 1/99

89 29603

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| Frances | F. | SCZEPUCHA | 10 / 30 / 89 | 11:15 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 218-44-2301 | 1 ☐ M 2 ☒ F | 43 YRS. | | | 9/8/46 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 929 Grove Hill Road | Arbutus | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Arbutus | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 929 Grove Hill Road | 21227 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Secretary | C & P Telephone Co. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Stanley F. Sczepucha | Virginia E. Albrecht |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Stanley F. Sczepucha | 1075 Downton Road Baltimore, Maryland 21227 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Meadowridge Memorial Park | Elkridge, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Louis F. Smith | Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Tamponade | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ruptured dissecting aortic aneurysm | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle, Jr., M.D. | OCME | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 vl

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

OHMH-18 Rev 1/89

89 29604

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Shirley B. Sanders
2. DATE OF DEATH — MONTH: 10 DAY: 26 YEAR: 89
3. TIME OF DEATH: 1935 (P M)
4. SOCIAL SECURITY NUMBER: 243-52-7016
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 51 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-18-38
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not Institution, give street and number): University Hosp. MFEMSS 22 South Green
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1900 Calais Ct.
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY? US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: Baltimore City Schools
17. FATHER'S NAME (First, Middle, Last): Shepard Burnette
18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma Jefferies
19a. INFORMANT'S NAME (Type/Print): Kenneth Sanders
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4910 Pembridge Ave., Baltimore, MD 21215
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Martin Chapel
20c. LOCATION — City or Town, State: Mebane, N.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. George Altenburg
22. NAME AND ADDRESS OF FACILITY: ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardio pulmonary Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Carotid Edema | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Carotid Vascular Accident | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 10/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29605

89 29605

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

2

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVA SOLNICK | | | | 2. DATE OF DEATH (Month, Day, Year): OCT. 29, 1989 | 3. TIME OF DEATH: 1:05 P M |
| 4. SOCIAL SECURITY NUMBER: 053-09-4693 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 95 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/30/94 | 8. BIRTHPLACE (State or Foreign Country): LITHUANIA |
| 9a. FACILITY NAME (If not institution, give street and number): OLD COURT NURSING HOME | | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2307 BAYTHORNE COURT | | | 10f. ZIP CODE: 21209 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | | 16b. KIND OF BUSINESS/INDUSTRY: HOMEMAKER | |
| 17. FATHER'S NAME (First, Middle, Last): ZALMAN PILVINSKY | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH UNKNOWN | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. JEANNE GOLDBERG | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2307 BAYTHORNE CT. BALTIMORE, MD. (21209) | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE HEBREW CEM. | | 20c. LOCATION — City or Town, State: REISTERSTOWN , MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joel D. Levinson | | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215) | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIOPULMONARY ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CONGESTIVE HEART FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
|---|---|

| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

| 29a. CERTIFIER (Check only one) | |
|---|---|
| 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | |
| 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. | |

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Howard B. Cohen M.D. | D21680 | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
6217 Park Heights Avenue 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29606

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH SWARTZ

2. DATE OF DEATH (Month, Day, Year): OCTOBER 28, 1989

3. TIME OF DEATH: 2:44 A M

4. SOCIAL SECURITY NUMBER: 220-07-1073

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

7. DATE OF BIRTH (Month, Day, Year): OCT. 21, 1904

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY

9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY:

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO

10e. STREET AND NUMBER: 2703 QUEEN ANNE ROAD

10f. ZIP CODE: 21216

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: XX

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 4

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

16b. KIND OF BUSINESS/INDUSTRY: AT HOME

17. FATHER'S NAME (First, Middle, Last): WILLIAM MEYER

18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN

19a. INFORMANT'S NAME (Type/Print): MR. MAX E. BLUMENTHAL

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 300 E. LOMBARD ST., BALTO., MD 21202

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HEBREW FRIENDSHIP

20c. LOCATION — City or Town, State: BALTIMORE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles M. Levinson

22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Sepsis | 2 hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Advanded Age | Yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Urinary tract infection | 7 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kirk Spencer MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KIRK Spencer 600 N. Wolfe Street BALT MD 21205

31. DATE FILED (Month, Day, Year): NOV 1 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29606

89 29607

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MINNIE B. STRONG | | | 2. DATE OF DEATH (Month, Day, Year): 10 / 26 / 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9/8/10 | 8. BIRTHPLACE (State or Foreign Country): South Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): 4626 FREEDOM WAY WEST | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4626 FREEDOM WAY (WEST) | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY? U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES: | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Sol BROWN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HATTIE Sober | |
| 19a. INFORMANT'S NAME (Type/Print): MONTREAL GREEN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8550 STEVENSWOOD Road 21207 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON MEM. PK. | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Deneatha Hecht #281 | 22. NAME AND ADDRESS OF FACILITY: E.L. PHILLIPS 1721 N. MONROE St. 21217 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Cerebral Hemorrhage | Minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Essential Hypertension | 3 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Eugene H. Owens M.D. | 29c. LICENSE NUMBER: DI2607 | 29d. DATE SIGNED (Month, Day, Year): 10-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. Eugene H. Owens 1733 E. Federal St. Balto, Md 21213

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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89 29608

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| ELSIE | Mae | STEWART | 10/30/89 | M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-30-8468 | 1 [X] M 2 [ ] F | 56 YRS. | | | 4 7 33 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 3416 Royce Avenue | Balto. | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | | Balto. | 1 [ ] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3416 Royce Avenue | 21215 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 11th | | Housekeeping | University Hosp. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Tucker | Luvenia Curleu |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Luvenia Alston | 3416 Royce Ave., Balto., Md. 21215 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Garrison Forest Vet. Cem. | Owings Mills, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | March F/H West 4300 Wabash Ave. |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrest. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertensive cardiovascular disease. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Hypertension | +10 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | — | M | 1 [ ] YES 2 [ ] NO | |
| | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — | | | 28l. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| B. P. Thada, M.D | D19823 | ▶ 10/31/89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| B. P. THADA. | 5356 Reisterstown Rd. |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29609

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

10

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BERNARD LEWIS ~~XXXXXXXX~~ SLATER | | | 2. DATE OF DEATH MONTH: 10 DAY: 29 YEAR: 89 | 3. TIME OF DEATH: 6 30 M |
| 4. SOCIAL SECURITY NUMBER: 213-07-0273 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12 31 1906 | 8. BIRTHPLACE (State or Foreign Country): Baltimore City |
| 9a. FACILITY NAME (If not institution, give street and number): Residence | 9b. CITY, TOWN OR LOCATION OF DEATH: Darlington | 9c. COUNTY OF DEATH: Harford | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Darlington | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1700 Castleton Rd. | 10f. ZIP CODE: 21034 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ------ College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Slater | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Hasse | |
| 19a. INFORMANT'S NAME (Type/Print): Lorraine M. Wilkerson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3711 Bay Rd. Street, Md. 21154 | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery | 20c. LOCATION — City or Town, State: Parkville.Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn | 22. NAME AND ADDRESS OF FACILITY: E.F.Lassahn Funeral home 11750 Belair Rd.Kingsville,Md. 21087 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard J. Colfer MD Dpt Med Examiner
29c. LICENSE NUMBER: DO 1194
29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RICHARD F. COLFER MD 2013 Tuttle Church Rd Darlington, Md 21034

31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

10

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

3

**1. DECEDENT'S NAME** (First, Middle, Last): OLIVE J. SHEWMAKE (Olive Joy Shewmake)

**2. DATE OF DEATH** Month: 10 Day: 28 Year: 89

**3. TIME OF DEATH**: 6:05 AM

**4. SOCIAL SECURITY NUMBER**: 216 36 8419

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 49 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 3-15-40

**8. BIRTHPLACE** (State or Foreign Country): MD

**9a. FACILITY NAME** (If not institution, give street and number): MERCY MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore City

**9c. COUNTY OF DEATH**: ======

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: ======

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 3802 4th Street

**10f. ZIP CODE**: 21225

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS** 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 10th Grade — College (1-4 or 5 +):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Paul Dornon

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Olive Spriggs

**19a. INFORMANT'S NAME** (Type/Print): Paul Dornon

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 379 Constitution Court Glen Burnie, Md. 21061

**20a. METHOD OF DISPOSITION** 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Cedar Hill Cemetery

**20c. LOCATION — City or Town, State**: Baltimore, Maryland

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Jerome Gronewurth

**22. NAME AND ADDRESS OF FACILITY**: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**23. PART I.** Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hypoxemia | 24hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Severe Anemia | 30 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Gastrointestinal bleeding | 30 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

**PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.**

Pneumonia
Multiple Sclerosis
Cerebrovascular accident

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH** 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Randolph Gorman MD MEDICAL RESIDENT

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): RANDOLPH GORMAN MD 301 ST. PAUL PLACE, BALTIMORE MD 21202

**31. DATE FILED** (Month, Day, Year): NOV 1 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR DAVID NICHOL SMITH

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DAVID N. SMITH- | | | | 2. DATE OF DEATH (Month, Day, Year): 10/29/89 | 3. TIME OF DEATH: 1.15 A M |
| 4. SOCIAL SECURITY NUMBER: 113-30-0889 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 55 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/20/33 | 8. BIRTHPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): HOWARD COUNTY GEN. HOSP. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA, MD | 9c. COUNTY OF DEATH: HOWARD |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: COLUMBIA | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6518 FRIETCHIE ROW | | 10f. ZIP CODE: 21045 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 [XX] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: KOREAN | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR | 16b. KIND OF BUSINESS/INDUSTRY: COMMUNICATIONS |
| 17. FATHER'S NAME (First, Middle, Last): RAYMOND F. SMITH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELFRIDA E. WART | |
| 19a. INFORMANT'S NAME (Type/Print): JOYCE SMITH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6518 FRIETCHIE ROW , COLUMBIA, MD. 21045 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY | 20c. LOCATION — City or Town, State: CATONSVILLE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such es cerdiec or reepiratory srrest, shock, or heart feilure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PROBABLE PULMONARY EMBOLISM. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CEREBRAL- VASCULAR ACCIDENT. (STROKE) | about 3 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Severe RESPIRATORY FAILURE | about 3 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. SEPSIS. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

TOXIC MEGACOLON - SUBTOTAL COLECTOMY. 8/22/89
cholecystectomy for acute cholecystitis 9/9/89
Tracheotomy for respiratory failure 9/5/89

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 8/3/89 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: STROKE - |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] DR. KIRAN PARIKH M.D | 29c. LICENSE NUMBER: D 26530 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4713 LEEDS AVE ARBUTUS, MD 21227. | | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. SIGNATURE OF REGISTRAR: [signature] | | |

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles W. Schmidt-Sr. | | 2. DATE OF DEATH (Month, Day, Year): 10 25 89 | 3. TIME OF DEATH: 1 25 PM |
| 4. SOCIAL SECURITY NUMBER: 218 24 6836 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JULY 4, 1931 |
| 8. BIRTHPLACE (State or Foreign Country): MARYLAND | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: PARKVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8611 WENDELL AVE. | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: KOREA | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS; College (1-4 or 5+): 4 YRS. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PROJECT ENG. | 16b. KIND OF BUSINESS/INDUSTRY: STATE ROADS COM. | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM J. SCHMIDT | 18. MOTHER'S NAME (First, Middle, Maiden Surname): AGNES EBER | | |
| 19a. INFORMANT'S NAME (Type/Print): FAMILY RECORDS | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKWOOD CEMETERY | 20c. LOCATION — City or Town, State: PARKVILLE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] T. Evans, Jr. | 22. NAME AND ADDRESS OF FACILITY: EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. metastatic gastric CA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. colon CA | 1987 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: D Boersma MD House officer PGY III | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 10/25/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Union Memorial Hospital David Boersma Baltimore MD 21218 | | |
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James A. Thibeault | | | | | 2. DATE OF DEATH: MONTH Oct. DAY 30 YEAR 1989 | 3. TIME OF DEATH: 0916 am |
| 4. SOCIAL SECURITY NUMBER: 031-01-4920 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-22-15 | 8. BIRTHPLACE (State or Foreign Country): Massachusetts |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1308 Stevens Ave. | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Auto Parts/Sales | 16b. KIND OF BUSINESS/INDUSTRY: Courier 1st N.B. | |
| 17. FATHER'S NAME (First, Middle, Last): Andrew J. Thibeault | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Dolan | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret A. Thibeault | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1308 Stevens Ave. Baltimore, MD 21227 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville Veterans Cemetery | 20c. LOCATION — City or Town, State: Crownsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Raymond Peterson | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory failure ~~cardiac failure~~ Error. ee | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Aspiration with ? hemoptysis (Pulmonary hemorrhage) | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Thrombocytopenia | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. Lymphoproliferative disorder. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder.
Multiple cerebral lesion.
COPD.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: E Chua, MD, Resident | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): St. Agnes Hospital Baltimore, MD 21229 | | |
| 31. DATE FILED (Month, Day, Year): NOV 14 1989 | [illegible] | |

OHMH-18 Rev 1/89

89 2913

89 29614

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| MILDRED | TAPPER | OCT. 28, 1989 | 5:10 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-18-6970 | 1 ☐ M 2 ☒ F | 69 YRS. | | | 5/30/20 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 9013 HAMOR RD. | RANDALLSTOWN | BALTIMORE |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. IHSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | RANDALLSTOWN | XX YES 2 ☐ NO |

| 10e. STREET AND HUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 9013 HAMOR RD. | 21133 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IH U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ HO | 1 ☐ YES 2 ☒ HO Specify: | Specify: WHITE |

| 15. OECEOENT'S EDUCATION (Specify only highest grade completed) | | 16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elamentary/Secondary (0-12) | College (1-4 or 5+) | | |
| 6 | | SALES | RETAIL |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S HAME (First, Middle, Malden Surname) |
|---|---|
| HARRY TAPPER | PAULINE LEVINSON |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| MRS. ETHEL OBERFELD | 27 STONEHENGE CIRCLE APT. 4, BALTO., MD (21208) |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) | KNESETH ISRAEL ANSHE KOLK CEM | BALTIMORE, MD. |

| 21. SIGNATURE OF FUHERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Sydney L. Stillman | SOL LEVINSON & BROS. 6010 REISTERSTOWN RD. BALTO., MD. (21215) |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory erreat, shock, or Heert failure. List only one cause on each line.

| | | Approximata Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. NAND | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentielly list conditions, if any, leading to immediete cause. Enter UNDERLYING CAUSE (Diseese or Injury that initieted events resulting in deeth) LAST | b. DUE TO (OR AS A COHSEOUEHCE OF): | |
| | c. OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

Brust Cancer (F)

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? | 26. PLACE OF OEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Hursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| 27. MANHER OF DEATH | 28a. DATE OF IHJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. IHJURY AT WORK? | 28d. OESCRIBE HOW IHJURY OCCUREO |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, date and place, and dus to the cause(s) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dus to the cause(s) and manner as stated.

| 29b. SIGNATURE AHD TITLE OF CERTIFIER | 29c. LICENSE HUMBER | 29d. DATE SIGHED (Month, Day, Yeer) |
|---|---|---|
| | D17012 | ▶ 10/28/89 |

30. HAME AND ADDRESS OF PERSOH WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)
Arthur M. LEBSON MD 3640 Fords Lane Balto MD 21215

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 2961

NOV 1 1989

89 29615

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

3

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| Bernice | S. | Timmings | 10 / 28 / 89 | 6:55 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-14-3635 | 1 ☐ M 2 ☒ F | 83 YRS. | | | 2-19-06 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 600 Light Street | Baltimore | ====== |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | ===== | Baltimore | 1 ☒ YES 2 ☐ NO |

| 10a. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 600 Light Street Apt. 228 | 21201 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8th Grade | | Clerk | A & P |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Alfred Heineman | Esther R. Jacobi |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Myra Dumbrowsky | 436 Jumper Court Glen Burnie, Maryland 21061 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | New Cathedral Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Jerome Zramiewicz | Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease and Diabetes | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin, M.D. | OCME | ▶ 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia C. Goodin, M.D. - Assistant 111 PEnn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

UNKNOWN 89-150

89 29616

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): UNKNOWN 89-150 | | 2. DATE OF DEATH (Month, Day, Year): 8-23-89 | 3. TIME OF DEATH: 9:04AM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday) YRS. / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year) / 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda | 9c. COUNTY OF DEATH: Montgomery County | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | |
| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in-state removal | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A Wood 10.31.89 | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Intracerebral hemorrhage | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence XXX Other (Specify) street | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 29c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita A Korell | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 8-23-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARGARITA A. KORELL,M.D. 111 Penn Street,Baltimore,MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Lydia Davidson-Randall |

DHMH-10 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNKNOWN 89-160

89 29617

1 · FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): UNKNOWN 89-160
2. DATE OF DEATH: MONTH 9-2-89 DAY YEAR
3. TIME OF DEATH: 1:00PM M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year):
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Swann Park-200 W. McComas Street
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE:
10b. COUNTY:
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER:
10f. ZIP CODE:
10g. CITIZEN OF WNAT COUNTRY?

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last):
18. MOTHER'S NAME (First, Middle, Maiden Surname):

19a. INFORMANT'S NAME (Type/Print):
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald S Wade 10-31-89
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BAORD, BALTO., MD. 21201

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Impramine (Tofranil) intoxication
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence [X] 6 Other (Specify) Scene

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident [X] 3 Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 9-2-89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES [X] 2 NO
28d. DESCRIBE HOW INJURY OCCURED: subject took drugs
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Found at Swann Park
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 200 blk. E. McComas St.,Balto. City, Maryland

29a. CERTIFIER (Check only one): [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes, M.D.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 9-20-89 Reissued

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes,M.D. 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

89 29617

89 29618

UNK.#89-158

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): UNKNOWN 89-158
2. DATE OF DEATH (Month, Day, Year): 8 31 89
3. TIME OF DEATH: 12:27 P.M
4. SOCIAL SECURITY NUMBER: -
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): - YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): -
8. BIRTHPLACE (State or Foreign Country): -
9a. FACILITY NAME (If not institution, give street and number): 4600 blk. Pulaski Hgwy.-RR tracks
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: -
10b. COUNTY: -
10c. CITY, TOWN OR LOCATION: -
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: -
10f. ZIP CODE: -
10g. CITIZEN OF WHAT COUNTRY: -
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): -
16b. KIND OF BUSINESS/INDUSTRY: -
17. FATHER'S NAME (First, Middle, Last): -
18. MOTHER'S NAME (First, Middle, Maiden Surname): -
19a. INFORMANT'S NAME (Type/Print): -
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): -
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald L. Wade 10-31-89
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Injuries
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) scene
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 8-31-89
28b. TIME OF INJURY: 12:08P.M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: pedestrian struck by train
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): railroad tracks
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4600 blk. Pulaski Hgwy.,Baltimore, Md.
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Margarita Korell
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 9-1-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. 111 Penn St., Balto., Md. 21201
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-18 Rev 1/89

89 29618

Unknown #89-172

89 29619

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): UNKNOWN 89-172
2. DATE OF DEATH: MONTH 9 DAY 22 YEAR 89
3. TIME OF DEATH: 9:45 A M
4. SOCIAL SECURITY NUMBER: -
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): - YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): -
8. BIRTHPLACE (State or Foreign Country): -

9a. FACILITY NAME (If not institution, give street and number): 310 E. Biddle Street
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: -
10b. COUNTY: -
10c. CITY, TOWN OR LOCATION: -
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: -
10f. ZIP CODE: -
10g. CITIZEN OF WHAT COUNTRY? -

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): - College (1-4 or 5+): -
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): -
16b. KIND OF BUSINESS/INDUSTRY: -

17. FATHER'S NAME (First, Middle, Last): -
18. MOTHER'S NAME (First, Middle, Maiden Surname): -

19a. INFORMANT'S NAME (Type/Print): -
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): -

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald Wade 10-31-89
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Stab wound of chest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) scene

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): unknown
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURRED: subject stabbed
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): unknown
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): unknown

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Charles P. Kokes MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 9-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles P. Kokes, M.D. 111 PennStreet Baltimore, MD 21201
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Erika Davidson-Randolph

DHMH-18 Rev 1/89

89 29620

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY MAY VENANZI | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 89 | 3. TIME OF DEATH: 1205 P M |
| 4. SOCIAL SECURITY NUMBER: 219-20-5247 | 5. SEX: 1 ☐ M 2 ☒ F | 8. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 5-11-1921 | 8. BIRTHPLACE (State or Foreign Coun.): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): STELLA MARIS | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 219 BALTIMORE AVENUE | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOME MAKER | | 16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC |
| 17. FATHER'S NAME (First, Middle, Last): JOHN G. YOUNGER, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EDNA MAY EMGE | | |
| 19a. INFORMANT'S NAME (Type/Print): DAVID A. VENANZI | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3563 MOULTREE PLACE BALTIMORE, MARYLAND 21236 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAK LAWN CEMETERY 10-31-89 | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK, MD 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | 2 mos. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ovarian Carcinoma | 1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 26c. INJURY AT WORK? | 26d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | 1 ☐ YES 2 ☐ NO | |
| 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | | ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JC DOWNS, MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | [signature] |

DHMH-16 Rev 1/89

89 2820

NOV 1 1989

89 29621

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

2

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HAZEL MILLS VARNELL | | | 2. DATE OF DEATH (Month, Day, Year): 10 27 89 | 3. TIME OF DEATH: 2:54 AM |
| 4. SOCIAL SECURITY NUMBER: 240-03-3687 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9-16-13 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Riviera Beach | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 8600 Main Avenue | 21122 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th Grade | | Seamstress | Clothing |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| | |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jeanette Munchel | 8600 Main Avenue Riviera Beach, Maryland 21122 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Cedar Hill Cemetery | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Richard E Davis | Gonce Funeral Home PA 4001 Ritchie Hwy. Baltimore, Md. 21225 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CORONARY ATHEROSCLEROSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE CHRONIC OBSTRUCTIVE LUNG DISEASE
~~ETC~~ HYPERTENSION

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Albin S. Kuhn II MD | D21336 | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALBIN KUHN II 1001 PINE HEIGHTS AVENUE SUITE 202 BALTIMORE MARYLAND 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29621

NOV 1 1989

89 29622

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Agnes WASHINGTON | | | | 2. DATE OF DEATH (Month, Day, Year): 10 19 89 | 3. TIME OF DEATH: 7.20 PM |
| 4. SOCIAL SECURITY NUMBER: 578-05-8260 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): May 28, 1905 | 8. BIRTHPLACE (State or Foreign Country): Wash DC |
| 9a. FACILITY NAME (If not institution, give street and number): Grosvenor Health Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda MD | | 9c. COUNTY OF DEATH: Montgomery | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: D.C. | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Washington | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2627 32nd St. S.E. | 10f. ZIP CODE: 20020 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Stock Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Dept. Store (McBrides) | |
| 17. FATHER'S NAME (First, Middle, Last): William Washington | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Moten | |
| 19a. INFORMANT'S NAME (Type/Print): Clarice K. Brown | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2330 Good Hope Rd.S.E.#519 Wash.D.C.20020 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. Bernard Hunt | | 22. NAME AND ADDRESS OF FACILITY: Hunt Funeral Home 2801 7th St.N.E. Wash.D.C.20017 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications thet ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory srrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of Breast | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D08542 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Tauber 8218 Wisconsin Ave Bethesda MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29622

Item 6 11-2-89 Film G657 W.H.

89 29623

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): IRENE M. WILKENS
2. DATE OF DEATH (Month, Day, Year): 10 23 89
3. TIME OF DEATH: 10:20 PM
4. SOCIAL SECURITY NUMBER: 217-01-3479
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): 12 6 18
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): BON SECOURS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 740 POPULAR GROVE STREET APT 18
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last):
18. MOTHER'S NAME (First, Middle, Maiden Surname): WINNIE SOUTHERLAND
19a. INFORMANT'S NAME (Type/Print): HAZEL HARRELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 COLBOURNE ROAD BALTO; MD
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE National Cem
20c. LOCATION — City or Town, State: BALTIMORE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Henry Harris
22. NAME AND ADDRESS OF FACILITY: MARSHALL P. HAYES F.H. 638 N. Gilmor St Baltimore, MD 21217

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. | CVA, new | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Respiratory Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Congestive Heart Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | hypertension | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous CVA
obesity
arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: 018327
29d. DATE SIGNED (Month, Day, Year): 10/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mugesh Pellevarayan 4660 Wilkens Av 21229
31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89 29624

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Annie Woods | | | | 2. DATE OF DEATH: MONTH 10 DAY 27 YEAR 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 220-07-0363 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 02-14-1902 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 4018 Barrington Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1827 Arunah Avenue | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. John Campbell | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2303 Wheatley Drive 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Auburn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph L. Russ | 22. NAME AND ADDRESS OF FACILITY: Joseph L. Russ Funeral Home, 222-26 West North Ave., Balto., MD 21216 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac arrhythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic Cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Multi-Infarct Dementia Due to Cerebrovascular Disease.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| George Taler, MD | D-19858 | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George Taler, M.D. 2200 N. Forest Park Ave. Baltimore, Md. 21207

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

89 2952

NOV 1 1989

89 29625

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joseph F. Watkins, Jr | | | 2. DATE OF DEATH (Month, Day, Year): October 29, 1989 | 3. TIME OF DEATH: 3:00 PM |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 31 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 4-1-1958 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 4411 Belleview Avenue | | 10f. ZIP CODE: | | 10g. CITIZEN OF WHAT COUNTRY? U S A |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Joseph F. Watkins, Sr | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Nickens | | |
| 19a. INFORMANT'S NAME (Type/Print): Charles Nickens | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4411 Belleview Avenue Baltimore, Md 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arbutus Memorial Park | | 20c. LOCATION — City or Town, State: Arbutus, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Portia Clr. | | 22. NAME AND ADDRESS OF FACILITY: North West. 4300 Wabash Ave | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Shock Secondary to Severe Upper Gastrointestinal Bleeding

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Alcoholic Cirrhosis and Portal Hypertension

DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Mahedin
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10.29.1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mohamed Mahedin, M.D. c/o/ Maryland General Hospital

31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DNMH-16 Rev 1/89

89 29626

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Thomas J. Wagner Jr. | | | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 89 | 3. TIME OF DEATH: 5:36 A M |
| 4. SOCIAL SECURITY NUMBER: 220-94-7525 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 18 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JUNE 6, 1971 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4064 ST. AUGUSTINE DRIVE | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGH SCHOOL; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONSTRUCTION | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): THOMAS WAGNER, SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DARLENE R. COLDWELL | |
| 19a. INFORMANT'S NAME (Type/Print): DARLENE R. BROWNE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7926 ST. MONICA DRIVE BALTIMORE, MARYLAND 21222 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLLY HILL MEMORIAL 10-31-89 | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Scott P. Gardner | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such aa cardiac or respiratory arrest, shock, or heart failure. List only one cause on asch lina.

| | | Approximsta Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finsl disease or condition resulting in death) → | a. Contact (through and through) gunshot wound right side of head | |
| Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO — Inspection | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10/28/89 | 28b. TIME OF INJURY: 4:15 A M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: Self inflicted |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 7926 St. Monica Dr,,Balto,MD (Dundalk) |

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 29) (Type, Print): Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto.MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 1 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29626

NOV 1 1989

89 29627

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

3

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SAMUEL WAGENHEIM | | | 2. DATE OF DEATH (Month, Day, Year): OCT. 28, 1989 | 3. TIME OF DEATH: 3:20 A M |
| 4. SOCIAL SECURITY NUMBER: 217-05-3336 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JULY 4, 1909 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 7219 PARK HEIGHTS AVE., APT. T-6 | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 7219 PARK HEIGHTS AVE., APT. T-6 | | 10f. ZIP CODE: 21208 | | 10g. CITIZEN OF WHAT COUNTRY?: usa |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AGENT | | 16b. KIND OF BUSINESS/INDUSTRY: INSURANCE |
| 17. FATHER'S NAME (First, Middle, Last): SIMON WAGENHEIM | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH KALLINSKY | | |
| 19a. INFORMANT'S NAME (Type/Print): HOWARD WAGENHEIM | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4315 WORTHINGTON AVE., GLYNDON, MD 21071 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON - CHIZUK AMUNO | | 20c. LOCATION — City or Town, State: BALTIMORE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stanley D. Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD., BALTO., MD 21215 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST: b. | cancer metastatic to brain DUE TO (OR AS A CONSEQUENCE OF): | 4 months |
| c. | Colon cancer DUE TO (OR AS A CONSEQUENCE OF): | 2 yrs |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)

1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Dan W Miller MD | D07421 | ▶ 10-28-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4000 Old Court Rd #300 21208

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29628

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lolette YORK
2. DATE OF DEATH (Month, Day, Year): Oct. 25, 1989
3. TIME OF DEATH: 2:50 p. M
4. SOCIAL SECURITY NUMBER: 801-16-3278
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/25/18
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 6109 FAIRDALE AVE.
10f. ZIP CODE: 21236
10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last):
18. MOTHER'S NAME (First, Middle, Maiden Surname):

19a. INFORMANT'S NAME (Type/Print): ELIZABETH ZANDER (friend)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6109 Fairdale Ave., Balto., Md. 21236

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):
20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald M Mills 10-31-89
22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Arrhythmia and Cardiac Ischemia.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Poor Nutritional status.
DUE TO (OR AS A CONSEQUENCE OF):
c. Status Post Gangrenous bowel.
DUE TO (OR AS A CONSEQUENCE OF):
d. Sepsis and Gastrointestinal bleed.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28l. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: B. Nakhleh, M.D.
29c. LICENSE NUMBER: AF232841852
29d. DATE SIGNED (Month, Day, Year): 10-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bash Nakhleh, M.D. 9000 Franklin Square Dr. Baltimore 21237.

31. DATE FILED (Month, Day, Year): NOV 1 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

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89 29629

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNA A. ZIEGLER
2. DATE OF DEATH (Month, Day, Year): 10-30-1989
3. TIME OF DEATH: 11:40 PM
4. SOCIAL SECURITY NUMBER: 214-01-9414D
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-4-1910
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: ------

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: ------
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7602 Bagley Ave.
10f. ZIP CODE: 21234
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Stephen Gunther
18. MOTHER'S NAME (First, Middle, Maiden Surname): Estella Mannion
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy A. Berends
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7602 Bagley Ave. Balto., Md. 21234
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hartley Miller
22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Wheeman MD
29c. LICENSE NUMBER: D37065
29d. DATE SIGNED (Month, Day, Year): Oct 31, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALISON MOLTERNO, MD Francis Scott Key Med Center Baltimore MD
31. DATE FILED (Month, Day, Year): NOV 8 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

OHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29629

89 29630

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| RAYMOND | S. | ZACHARKO | Oct. 31, 1989 | 1:30 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-28-2881 | 1 XX M 2 ☐ F | 61 YRS. | | | 2-11-1928 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1802 Berrywood Road | Parkville | Baltimore Co. |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore Co. | Parkville | 1 ☐ YES 2 XX NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1802 Berrywood Road | 21234 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 1958 - 1960 | 1 ☐ YES 2 XX NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 Years | 2 Years | Accountant | Insurance |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Michael Zacharko | Veronica Myszkowski |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mafi H. Zacharko | 1802 Berrywood Road Baltimore, Maryland 21234 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mt. Maria Cemetery | Towson, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| William E. Johnson | William E. Johnson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21204 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Adeno Carcinoma of lung to brain | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Carl Sperling MD | D28987 | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CARL SPERLING MD 5601 LOCH RAVEN BLVD 21239

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 1 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29630

89 29631

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in filing the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVA. M. ANDERSON | | | 2. DATE OF DEATH MONTH 10 DAY 28 YEAR 89 | 3. TIME OF DEATH 840 PM |
| 4. SOCIAL SECURITY NUMBER: 237-36-7138 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 04/27/23 | 8. BIRTHPLACE (State or Foreign Country): USA |
| 9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4140 REISTERTOWN RD | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): JONAH Anderson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jamie Newsome | |
| 19a. INFORMANT'S NAME (Type/Print): Jean Conway | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4140 Reisterstown Rd. 21215 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star | 20c. LOCATION — City or Town, State: Balto. County | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lola March | | 22. NAME AND ADDRESS OF FACILITY: Wm. C. March Funeral Home 4300 Wabash Ave. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one cause on each line.

| | | Approximeta Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HEPATIC FAILURE | 1 Mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if sny, lesding to immedieta cause. Enter UNDERLYING CAUSE (Diseasa or injury that initiated events resulting in death) LAST | b. SEPTCEMIA | 1 WK |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. PNEUMONIA | 1 d. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERREO TO MEOICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. OATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. OESCRIBE HOW INJURY OCCUREO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(a) end menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Rajesh Chawla House Staff | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/28 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAJESH CHAWLA SINAI HOSPITAL BALTIMORE | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

DHMH-18 Rev 1/89

89 23631

89 29632

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH (Month, Day, Year) | | 3. TIME OF DEATH |
| Clayton | BROWNING | | | | October 31, 1989 | | 11:20A |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) |
| 214-16-2927 | 1 [X] M 2 [ ] F | 67 YRS. | | | Nov. 16 1921 | | MAryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Franklin Square Hospital | Rossville | Baltimore |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Baltimore | Middle River | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 16 Hydroplane Drive | 21220 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8th | | Laborer | Brickyard |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Bert Browning | Alma Lee |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Annie Shanholtz | Box 168 Wiley Ford West Virginia 26767 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Dulaney Valley Cemetery | Baltimore Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Connelly Funeral Home | Connelly Funeral Home 300MAceAve. 21221 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Squamous cell carcinoma of lung | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Massive hemoptysis and S.O.B.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Maria C. Sam MD | N/A | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Sam 9000 Franklin Square Drive Baltimore, MD 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DHMH-16 Rev 1/89

89 29632

89 29633

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie Ledebour Abbott Byus | | | | | 2. DATE OF DEATH (Month, Day, Year): Oct. 29 1989 | | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 217-46-2457 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Dec. 9 1898 | | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Masonic Home of Maryland | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville | | 9c. COUNTY OF DEATH: Baltimore | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Cockeysville | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | | |
| 10e. STREET AND NUMBER: 300 International Circle | | 10f. ZIP CODE: 21030 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking | | |
| 17. FATHER'S NAME (First, Middle, Last): Maxwell E. Abbott | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ledebur | | |
| 19a. INFORMANT'S NAME (Type/Print): Vernon H. Byus, Jr. | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2213 Westridge Rd., Timonium, Md. 21093 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery | | | 20c. LOCATION — City or Town, State: Balto., Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martin D. Lawson | | | | | 22. NAME AND ADDRESS OF FACILITY: Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c. Esophageal Ulcers
DUE TO (OR AS A CONSEQUENCE OF):
d. Dementia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul M. Rivas | D25488 | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul M. Rivas, M.D., 3421 Sweet Air Rd., Phoenix, Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Edith Davidson-Randall |

DHMH-16 Rev 1/89

89 29634

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by use of the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frank E. BASS | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 26 / 89 | 3. TIME OF DEATH: 8:18 A M |
| 4. SOCIAL SECURITY NUMBER: 408-07-4943 | 5. SEX: 1 ☒ M 2 ☐ F | 8. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/18/14 | 8. BIRTHPLACE (State or Foreign Country): Tennessee |
| 9a. FACILITY NAME (If not institution, give street and number): AMI DOCTORS' HOSPITAL OF P.G. COUNTY | | 9b. CITY, TOWN OR LOCATION OF DEATH: Lanham | 9c. COUNTY OF DEATH: Prince George's | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD. | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Largo | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 10241 Prince Place | 10f. ZIP CODE: 20772 | 10g. CITIZEN OF WHAT COUNTRY?: United States | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired | 16b. KIND OF BUSINESS/INDUSTRY: Government | | |
| 17. FATHER'S NAME (First, Middle, Last): Henry Bass | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eliza Batey | | | |
| 19a. INFORMANT'S NAME (Type/Print): Dottie Bass | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10241 Prince Place, Largo, Maryland | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery | 20c. LOCATION — City or Town, State: Arlington, VA. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John T. Stewart, III | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Rd., N.E. Wash. D.C. 20019 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | 5 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CONGESTIVE HEART FAILURE | ~1 month |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DILATED CARDIOMYOPATHY | >1 year |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D37561 | ▶ 10/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EGAV BARR MD, 42 SPYCE MILL CT, RANDALLSTOWN, MD, 21133

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Gloria Davidson-Randall |

DHMH-16 Rev 1/89

89 29631

89 29635

Items:23,27 per ME G-657
11-29-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEM:23 per ME G-660 2-16-90 cm

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joan Graham Brown | | | | | 2. DATE OF DEATH (Month, Day, Year): 10-31-89 | 3. TIME OF DEATH: 6:49AM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 46 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/13/43 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | | BALATIMORE CITY | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2850 FOREST GLEN ROAD | 21207 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 6+) | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| WELLINGTON GRAHAM | BEATRICE SINGLETON |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JORDAN FUNERAL HOME | 306 S. 7th STREET: WILMINGTON, NC 28401 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | PINE FOREST CEMETERY | WILMINGTON, N.C. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Leroy O. Dyett | LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ~~Cardiomyopathy~~ MYOCARDIAL FIBROSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient ☒ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin, M.D. | OCME | ▶ 11-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Gloria Gardner-Randall |

DHMH-16 Rev 1/89

89 29636

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anna May Baker | | | 2. DATE OF DEATH (Month, Day, Year): October 31, 1989 | 3. TIME OF DEATH: 7:30A M |
| 4. SOCIAL SECURITY NUMBER: 215-01-9350 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 1 1915 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: -------- |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: -------- | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1012 Evans Way | | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): George Daniels | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Moore | |
| 19a. INFORMANT'S NAME (Type/Print): Charles A. Baker, Sr.-husband | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1012 Evans Way, Baltimore, Md. 21205 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Baltimore Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian D. Lewis | 22. NAME AND ADDRESS OF FACILITY: Schimunek Funeral Home Inc. 3331 Brehms Lane, Balto. Md. 21213 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Persistant Hypotension

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

c. Multiple Organ system failure

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease
~~Pneumonia~~ Empyema
Siabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: B.D. Norris, MD | 29c. LICENSE NUMBER: n/a | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Brent Norris, M.D. c/o Maryland General Hospital | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Elaine Davidson-Randall | |

DHMH-16 Rev 1/89

89 29636

89 29637

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): RUTH HILLIARD BIRCKHEAD
2. DATE OF DEATH (Month, Day, Year): 10 30 89
3. TIME OF DEATH: 10:00pm M
4. SOCIAL SECURITY NUMBER: 219 42 2115
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 96 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 9 9 1893
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): PICKERSGILL
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTO.

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: BALTO.
10c. CITY, TOWN OR LOCATION: Towson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 615 CHESTNUT AVE.
10f. ZIP CODE: 21204
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Grocery Store
17. FATHER'S NAME (First, Middle, Last): EMMANUEL Hilliard
18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Fox
19a. INFORMANT'S NAME (Type/Print): Pickersgill Home
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery 11/2/89
20c. LOCATION — City or Town, State: Woodlawn, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. aspiratia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY:
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Stoltz, m
29c. LICENSE NUMBER: D36912
29d. DATE SIGNED (Month, Day, Year): 10/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert Stoltz, M.D., Pot Spring Rd., Timonium, Md. 21093
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson

DHMH-16 Rev 1/89

89 29638

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ardis M. Blackburn
2. DATE OF DEATH (Month, Day, Year): October 30, 1989
3. TIME OF DEATH: 6:45 A. M
4. SOCIAL SECURITY NUMBER: 218-26-4207
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 14, 1896
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Dulaney Towson Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Lutherville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 114 Ardoon Road
10f. ZIP CODE: 21093
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 6
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Frank Baldwin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Cook

19a. INFORMANT'S NAME (Type/Print): Charles P. Blackburn
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same As #10

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematory 10-31-89
20c. LOCATION — City or Town, State: Baltimore, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr.
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD — DUE TO (OR AS A CONSEQUENCE OF): — 5+yr

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. _____ DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles F. O'Donnell
29c. LICENSE NUMBER: D-09383
29d. DATE SIGNED (Month, Day, Year): ▶ 30 October 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles F. O'Donnell M.D. 7501 York Road, Towson, Maryland 21204

31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29639

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Frances Corso | | | 2. DATE OF DEATH (Month, Day, Year): October 30, 1989 | 3. TIME OF DEATH: 10:45a M |
| 4. SOCIAL SECURITY NUMBER: 218-36-0402 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 8 1938 | 8. BIRTHPLACE (State or Foreign Country): MAryland |
| 9a. FACILITY NAME (If not institution, give street and number): 7507 Lange Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Eastpoint | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Eastpoint | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7507 Lange Street | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEHDENT OF HISPAHIC ORIOIN? (Specify Yes or Ho— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDEHT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIHD OF BUSINESS/INDUSTRY | |
| 17. FATHER'S HAME (First, Middle, Last): Joseph Nevins | | 18. MOTHER'S HAME (First, Middle, Maiden Surname): Daisy Bickford | |
| 19a. IHFORMAHT'S HAME (Type/Print): John Corso | 19b. MAILIHO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7507 Lange Street Baltimore MAryland 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holly Hill Cemetery | 20c. LOCATION — City or Town, State: Balto. Md. | |
| 21. SIGNATURE OF FUHERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AHD ADDRESS OF FACILITY: Connelly Funeral Home 300MAce Ave. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic lung Ca — DUE TO (OR AS A CONSEQUEHCE OF): — 17 months

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. — DUE TO (OR AS A COHSEQUENCE OF):

c. — DUE TO (OR AS A CONSEQUEHCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDIHGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ HO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MAHHER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ HO | 28d. DESCRIBE HOW IHJURY OCCURED |
| | 28e. PLACE OF IHJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYIHG PHYSICIAH: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMIHER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGHATURE AHD TITLE OF CERTIFIER: M. Connell Med Physician | 29c. LICEHSE HUMBER: D19714 | 29d. DATE SIGHED (Month, Day, Year): ▶ 10/31/89 |
| 30. NAME AND ADDRESS OF PERSOH WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REOISTRAR'S SIGNATURE: Felicia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGUERITE M. CAHILL | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 21 / 89 | 3. TIME OF DEATH: 5:00 A M |
| 4. SOCIAL SECURITY NUMBER: 218-40-6656 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): ~~88~~ 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11/21/11 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): 1220 RIDERVALE RD. | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: TOWSON | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1220 RIDERVALE DR. | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): — | 16b. KIND OF BUSINESS/INDUSTRY: — |
| 17. FATHER'S NAME (First, Middle, Last): — | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): — | |
| 19a. INFORMANT'S NAME (Type/Print): Terrance Cahill (spouse) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1220 Ridervale Dr., Towson, Md. 21204 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald L Wade 11-1-89 | | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HEMANGIOPERICYTOMA (MALIGNANT) | 1 year |
| DUE TO (OR AS A CONSEQUENCE OF): | b. (METASTASIS due to (a)) | 3 MONTHS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Aortic Sclerosis & Mitral regurgitation

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D00509 | 29d. DATE SIGNED (Month, Day, Year): 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR BERSTOCK. 302 E 33rd St BALTO MD 21218.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CADDEN ANTOINETTE E.
2. DATE OF DEATH (Month - Day - Year): 10 - 31 - 89
3. TIME OF DEATH: 12:30 AM
4. SOCIAL SECURITY NUMBER: 215-01-9564
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (If yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 12-10-10
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 3724 E. Lombard Street
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): -----
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): George Swope
18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Ketchenreuter
19a. INFORMANT'S NAME (Type/Print): Robert E. Cadden
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1021 Bowleys Quarters Road Balto. Md. 21220
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem.
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph N. Zannino Jr.
22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street Balto. Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death) → a. HEPATOMA WITH METASTASIS

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): b. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 10/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Liberty Medical Center
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be removed and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Richard A. Cushing | | | | 2. DATE OF DEATH (Month, Day, Year): 10 28, 1989 | | 3. TIME OF DEATH: 3:43 P M |
| 4. SOCIAL SECURITY NUMBER: 213-34-4060 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 51 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): NOV. 9, 1937 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Fallston | | | 9c. COUNTY OF DEATH: Harford |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: KINGSVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 6839 SUNSHINE AVENUE | | 10f. ZIP CODE: 21087 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: PEACE TIME | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCK DRIVER | 16b. KIND OF BUSINESS/INDUSTRY: DELIVERY COMPANY | |
| 17. FATHER'S NAME (First, Middle, Last): SAMUEL J. CUSHING | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): KATE CREAGH | |
| 19a. INFORMANT'S NAME (Type/Print): NANCY L. CUSHING (WIFE) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6839 SUNSHINE AVENUE, KINGSVILLE, MARYLAND 21087 | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAKLAWN CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brian D Lewis | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD BALTIMORE, MARYLAND 21236 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Nephrolithiasis and Prostatic carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Frank J. Peretti, MD | OCME | 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank J. Peretti, M.D. - Assistant 111 Penn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Erika Davidson-Randall |

DHMH-18 Rev 1/89

WARREN Capers

89 29643

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WARREN CAPERS
2. DATE OF DEATH (Month, Day, Year): 10 27 1989
3. TIME OF DEATH: 3:15 PM
4. SOCIAL SECURITY NUMBER: 250-12-2695
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 70 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-18-19
8. BIRTHPLACE (State or Foreign Country): S. C.
9a. FACILITY NAME (If not institution, give street and number): SCTOR NURSING HOME 581 WILKENSON ST
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 2139 W. LEXINGTON ST.
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER
16b. KIND OF BUSINESS/INDUSTRY: IRON/METAL INDUSTRY
17. FATHER'S NAME (First, Middle, Last): THOMAS CAPERS
18. MOTHER'S NAME (First, Middle, Maiden Surname): BERTHA CAPERS
19a. INFORMANT'S NAME (Type/Print): THOMASENA HESTER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2139 W. LEXINGTON ST BALTO MD 21223
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN SDR Cemetery
20c. LOCATION — City or Town, State: Catonsville, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Rodney Lusk
22. NAME AND ADDRESS OF FACILITY: ~~LUSK FUNERAL SERVICE~~ OFFICE: 4644 PIMLICO ROAD BALTIMORE, MD 21215

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Prostatic Cancer — Approximate Interval Between Onset and Death: 2 yrs.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jaime Punzalan MD
29c. LICENSE NUMBER: D15724
29d. DATE SIGNED (Month, Day, Year): 10/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAIME PUNZALAN - 6214 Hunting rd. Balto. Md.

31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 25843

89 29644

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jake Daniel. | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 30 / 89 | | 3. TIME OF DEATH: 4 A M |
| 4. SOCIAL SECURITY NUMBER: 229-48-6637 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 49 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-3-39 | | 8. BIRTHPLACE (State or Foreign Country): VA. |
| 9a. FACILITY NAME (If not institution, give street and number): MFL/FSK Eastern Ave | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 515 N. Robinson Street | | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: B/k. |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chemical Operator | 16b. KIND OF BUSINESS/INDUSTRY: Allied Chemical | |
| 17. FATHER'S NAME (First, Middle, Last): Jake W. Daniels | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Jones | |
| 19a. INFORMANT'S NAME (Type/Print): JEAN McCLAIRN | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 515 N. Robinson St. / Balto. MD 21205 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Lawn Cem. | 20c. LOCATION — City or Town, State: Fredricksburg, VA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: Wm. C. March Funeral Home 1101 E. North Avenue 21202 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia / Sepsis. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Shy Drager | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Atonic Bladder | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. V-T D | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: GTT — Depression.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D04383 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Linda Fac 5200 Eastern Ave Baltimore Md. | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

83 SEP 14

89 29645

Item #14 per FH sp

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Reginald Drummond | | | | | 2. DATE OF DEATH (Month, Day, Year): 10-24-89 | | 3. TIME OF DEATH: 8:45PM M |
| 4. SOCIAL SECURITY NUMBER: 213-90-6692 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 25 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-2-63 | | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | | 10c. CITY, TOWN OR LOCATION: Baltimore | | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 14 S. Rosedale St. | | | 10f. ZIP CODE: 21229 | | | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: ~~USA~~ Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Firefighter | | 16b. KIND OF BUSINESS/INDUSTRY: Protective Safety | | |
| 17. FATHER'S NAME (First, Middle, Last): Rufus Drummond | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lizzie M. Jones | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Lizzie M. Jones | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 S. Rosedale St. Balto., Md. 21229 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pinelawn Memorial Park | | 20c. LOCATION — City or Town, State: Annapolis, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Derrick C. Jones | | | 22. NAME AND ADDRESS OF FACILITY: Derrick C. Jones F.H. 4611 Park Heights Avenue 21215 | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple gunshot wounds | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 10-24-89 | 7:00PM | 1 [ ] YES [X] NO | Subject shot |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Street

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): North Ave. & Ruxton Avenue, Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 10-25-89 |

29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM #27) (Type, Print): Julia C. Goodin,MD 111 Penn Street Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and ... burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29646

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eric Michael Dean | | | 2. DATE OF DEATH (Month, Day, Year): 10-30-89 | 3. TIME OF DEATH: 7:19PM M |
| 4. SOCIAL SECURITY NUMBER: 214-76-0572 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 17 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 9-29-1972 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8739 Cimarron Cir. | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 Yrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Carl W. Dean | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary B. Bayer | |
| 19a. INFORMANT'S NAME (Type/Print): Carl W. Dean | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8739 Cimarron Cir., Balto., Md. 21234 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify): | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Cem. 11-2-89 | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather (Roy H. Cather) | | 22. NAME AND ADDRESS OF FACILITY: Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Close range gunshot wound to head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10-30-89 | 28b. TIME OF INJURY: 6:30PM | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Subject accidentally shot by gun while unjamming | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Basement | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 6206 Falkirk Road, Baltimore City Maryland | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golley Jr. MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 10-31-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Mario F. Golley, Jr., MD — 111 Penn Street, Baltimore, MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES HENRY FLINT
2. DATE OF DEATH (Month, Day, Year): Nov. 1 1989
3. TIME OF DEATH: 3.31 A M
4. SOCIAL SECURITY NUMBER: 212-30-7621
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Mar. 28, 1933
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: City
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 818 Stoll Street
10f. ZIP CODE: 21225
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+): none
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Driver
16b. KIND OF BUSINESS/INDUSTRY: Baltimore City
17. FATHER'S NAME (First, Middle, Last): Robert J. Flint Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine C. Brown
19a. INFORMANT'S NAME (Type/Print): Catherine C. Owings
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3000 Vermont Ave. Balt. MD 21227
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial
20c. LOCATION — City or Town, State: Elkridge, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold B Simson
22. NAME AND ADDRESS OF FACILITY: #1 Second Ave.S.W. SINGLETON FUNERAL HOME, Glen Burnie 21061

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest-
DUE TO (OR AS A CONSEQUENCE OF):
b. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c. ETOH Ubuse.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N. A
28b. TIME OF INJURY: NA M
28c. INJURY AT WORK? NA — 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: NA
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N. A.
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N.A
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SUED T.A. RIAZ 1301 Lincoln wds. DRIVE Balti MD 21228
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from page 4 and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. The burial-transit permit. Pages 1, 2, 3 should
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29648

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Nellie | Gordon | Freeman | 10-29-1989 | 2:40 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-10-7166 | 1 ☐ M 2 ☒ F | 102 YRS. | | | 8-31-1887 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| The Wesley Home, Inc. | Baltimore | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | -------- | Baltimore, | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2211 W. Rogers Ave. | 21209 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Homemaker | Homemaker |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Laurence Hickman | Laura Ball |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| The Wesley Home | 2211 W. Rogers Avenue Balto., MD 21209 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Dulaney Valley Memorial | Cockeysville, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Walter Henss | Burgee-Henss Funeral Home 3631 Falls Road Balto., MD 21211 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADVANCED AGE + MULTISYSTEM FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ORGANIC BRAIN SYNDROME

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Robert Fuberto, MD (Attending Phys.) | D21464 | ▶ 10-31-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

3508 BANK ST. BALTO, Md 2124

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. This will serve as the transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN MI GRIFFIN
2. DATE OF DEATH (Month, Day, Year): OCT 30 1989
3. TIME OF DEATH: 1400 EST AM PM
4. SOCIAL SECURITY NUMBER: 239-12-3183
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-21-1917
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): University Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1213 Light Street
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 1/44 - 3/46
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): (illegible) — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disable
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): William Griffin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Maggie Monroe
19a. INFORMANT'S NAME (Type/Print): William Griffin
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Sherwood Lane Voorhees N.J. 08043
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gatewood Forest
20c. LOCATION — City or Town, State: Owings Mill, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: (signature)
22. NAME AND ADDRESS OF FACILITY: Jeff Miller F/H 1639 N. Broadway Balto. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | GASTROINTESTINAL BLEED | 14 days |
| DUE TO (OR AS A CONSEQUENCE OF): b. | FACTOR VIII INHIBITOR | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RETROPERITONEAL BLEED; AORTIC (ABDOMINAL) ANEURYSM

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: (signature)
29c. LICENSE NUMBER: 038863
29d. DATE SIGNED (Month, Day, Year): 10-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRY J GERMACK
2. DATE OF DEATH (Month, Day, Year): NOV 1ST 1989
3. TIME OF DEATH: 3:45 PM
4. SOCIAL SECURITY NUMBER: 217-16-3942
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 3 / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-1-1917
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): LITTLE FIELD BOARDING HSE
9b. CITY, TOWN OR LOCATION OF DEATH: DARLINGTON
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: HARFORD
10c. CITY, TOWN OR LOCATION: DARLINGTON
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4303 CONOWINGO RD
10f. ZIP CODE: 21034
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist
16b. KIND OF BUSINESS/INDUSTRY: CRown Cork & Seal

17. FATHER'S NAME (First, Middle, Last): Henry Germack Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): MArie Dwyer

19a. INFORMANT'S NAME (Type/Print): Mary Sewell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3826 Rush Road Jarretsville Md. 21084

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak LAwn Cemetery
20c. LOCATION — City or Town, State: Balto. Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MAceAve. 21221

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIORESPIRATORY ARREST | 3 HRS. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CORONARY ARTERY DISEASE | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: LEFT CEREBROVASCULAR ACCIDENT

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A.

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: DME
29c. LICENSE NUMBER: D 21809
29d. DATE SIGNED (Month, Day, Year): ▶ NOV 1ST 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GANESH S. PRABHU 1810 BELAIR RD #102 FALLSTON MD 21047

31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Robert Marion Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DANIEL G. GRAMPP
2. DATE OF DEATH (Month, Day, Year): OCTOBER 31, 1989
3. TIME OF DEATH: 9:21 P M
4. SOCIAL SECURITY NUMBER: 220-07-7497
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-4-21
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3809 Gough Street
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th — College (1-4 or 5+): --------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpneter
16b. KIND OF BUSINESS/INDUSTRY: Sparrows Point
17. FATHER'S NAME (First, Middle, Last): William Grampp
18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Keller
19a. INFORMANT'S NAME (Type/Print): Lynn Dunkerly
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 701 Marlboro Road Glen Burnie, Md. 21061
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cem.
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph N. Zannino
22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street Balto. Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Arrythmia (Ventricular Fibrillation) | 30 minutes |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Ischemic Cardiomyopathy | 3 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Coronary Artery disease | 6 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: tobacco use

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATIDN (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Lankford J Hyps MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR JOSEPH ELMER GRAVES

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use with the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH E. GRAVES | | | 2. DATE OF DEATH (Month, Day, Year): 10 29 1989 | 3. TIME OF DEATH: 8:47 A M |
| 4. SOCIAL SECURITY NUMBER: 578 30 2819 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03-08-1929 | 8. BIRTHPLACE (State or Foreign Country): Wash. DC |
| 9a. FACILITY NAME (If not institution, give street and number): REEDERS MEMORIAL HOME | | 9b. CITY, TOWN OR LOCATION OF DEATH: BOONSBORO | | 9c. COUNTY OF DEATH: WASHINGTON |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: North Beach Park | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1099 Bayfront Ave | | 10f. ZIP CODE: 20714 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korean | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager (PEPCO) | | 16b. KIND OF BUSINESS/INDUSTRY: Utilities |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Elmer Graves, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Beck | | |
| 19a. INFORMANT'S NAME (Type/Print): Frances D. Graves | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 above | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. Veterans Cemetery | | 20c. LOCATION — City or Town, State: Cheltenham, (PG) MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. Michael Ryan RFH | | 22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Approximate Interval Between Onset and Death: 48 hours

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Organic brain Syndrome

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R. L. Ryder MD | 29c. LICENSE NUMBER: D 26579 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. L. Ryder MD Geeby Lane Frederick, MD 21756 | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NEAL C. GALLAGHER SR. | | 2. DATE OF DEATH (Month, Day, Year): October 30, 1989 | 3. TIME OF DEATH: 11:10 AM |
| 4. SOCIAL SECURITY NUMBER: 179-14-4598 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb 21 1922 |
| 8. BIRTHPLACE (State or Foreign Country): Penna. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: ------ | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3521 WOODSTOCK AVE. | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MACHINIST | 16b. KIND OF BUSINESS/INDUSTRY: ----- | |
| 17. FATHER'S NAME (First, Middle, Last): JOHN GALLAGHER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY McGROATY | | |
| 19a. INFORMANT'S NAME (Type/Print): RITA GALLAGHER (WIFE) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3521 WOODSTOCK AVE., BALTO. MD. 21213 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEMETERY | 20c. LOCATION — City or Town, State: BALTO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Carcinoma of Parotid DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? X 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D02985 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Breschi 9000 Franklin Square Drive Baltimore, MD 21237 | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lizzie M. Harlow | | 2. DATE OF DEATH (Month, Day, Year): 10 27 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 223-22-9508 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-19-23 |
| 8. BIRTHPLACE (State or Foreign Country): Va. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 5704 Johnnycake Rd. | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md. | 9c. COUNTY OF DEATH: Baltimore Co. | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: N/A | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5704 Johnnycake Rd. - Baltimore, Md. | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: N/A | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: N/A | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: N/A | |
| 17. FATHER'S NAME (First, Middle, Last): Hugh Millirons | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mae Lambert | | |
| 19a. INFORMANT'S NAME (Type/Print): Virginia Margaritis | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1416 Langford Rd.-Baltimore, Md. 21207 | | |
| 20a. METHOD OF DISPOSITION: 10-30-89 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ G. Truman Schwab | 22. NAME AND ADDRESS OF FACILITY: 5151 Baltimore National Pike Baltimore, Md. 21229 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal cell carcinoma (metastatic) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas Ira Sweet MD.

29c. LICENSE NUMBER: D 35853

29d. DATE SIGNED (Month, Day, Year): ▶ Oct. 27, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas Ira Sweet, MD. 22 South Greene St. Balto MD 21201

31. DATE FILED (Month, Day, Year): NOV 2 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 29655

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT T. HILL | | | | | | 2. DATE OF DEATH (Month, Day, Year): 10 30 89 | 3. TIME OF DEATH: 8:15 P M |
| 4. SOCIAL SECURITY NUMBER: 406-01-6780 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | 7. DATE OF BIRTH (Month, Day, Year): 6-4-19 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE COUNTY | 10c. CITY, TOWN OR LOCATION: Rossville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8207 OLD PHILADELPHIA RD | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: Beth Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Issac Tillman Hill | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Arilla Minton | |
| 19a. INFORMANT'S NAME (Type/Print): Edna Hill | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8207 OldPhiladephia Road Balto. Md. 21237 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Rossville MAryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MaceAve. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CA LUNG W/METASTASIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Beena Nagpal | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BEENA NAGPAL CHURCH HOSPITAL CORPORATION

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and may be used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 days after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to page 4 as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Theodore M. Haught
2. DATE OF DEATH — MONTH: 10 DAY: 31 YEAR: 89
3. TIME OF DEATH: 955 A M
4. SOCIAL SECURITY NUMBER: 172 20 8913
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-18-24
8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): Loch Raven VA Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: ~~3105 Four Seasons Ct.~~ 3457 Liberty Parkway
10f. ZIP CODE: 21222
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance
16b. KIND OF BUSINESS/INDUSTRY: Good Samaritan Hospital
17. FATHER'S NAME (First, Middle, Last): Furman Haught
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annabelle McMasters
19a. INFORMANT'S NAME (Type/Print): Mildred Haught
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3457 Liberty Parkway Baltimore MAryland 21222
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Cemetery
20c. LOCATION — City or Town, State: Baltimore MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Connelly Funeral Home
22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 21222

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Glioblastoma multiforme | 7 mos. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
(1) Anemia
(2) S/P pseudomonas urinary tract infection

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) — 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jean K. Warner MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 10/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jean K. Warner MD Loch Raven VA Hosp Loch Raven Blvd Baltimore, MD
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EARL A HILL
2. DATE OF DEATH (Month, Day, Year): 10 27 89
3. TIME OF DEATH: 1124 M
4. SOCIAL SECURITY NUMBER: 218-03-8821
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-27-1912
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: M.D.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3406 ALTO Rd
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LONGSHOREMAN
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): James Hill
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Reed
19a. INFORMANT'S NAME (Type/Print): Alice DeShazo
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3406 Alto Rd Balto. M.D. 21216
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. CALVARY Cemetery
20c. LOCATION — City or Town, State: Balto. M.D.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Clarence L. Reed
22. NAME AND ADDRESS OF FACILITY: Reed Funeral Service 1721 N. Monroe St 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Stroke with occipital infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Hypertension, Diabetes Mellitus | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sher A Hashmi
29c. LICENSE NUMBER: D24648
29d. DATE SIGNED (Month, Day, Year): ▶ 10-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHER HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMOR 21215

31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sloan Stanley HODGES
2. DATE OF DEATH (Month, Day, Year): October 30, 1989
3. TIME OF DEATH: 2:45 A M
4. SOCIAL SECURITY NUMBER: 265-09-2639
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 15, 1913
8. BIRTHPLACE (State or Foreign Country): South Carolina
9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Lanham
9c. COUNTY OF DEATH: Prince Georges'

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges'
10c. CITY, TOWN OR LOCATION: Kettering
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 12800 Cambleton Drive
10f. ZIP CODE: 20772
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 8+): 4 Years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister
16b. KIND OF BUSINESS/INDUSTRY: Religion
17. FATHER'S NAME (First, Middle, Last): George Hodges
18. MOTHER'S NAME (First, Middle, Maiden Surname): Melissa (Unknown)
19a. INFORMANT'S NAME (Type/Print): Martha R. Hodges
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12800 Cambleton Dr., Kettering, MD.
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John T. Stewart, III
22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home, 4001 Benning Rd., N.E. Washington, D.C.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular Accident

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James Cheley MD
29c. LICENSE NUMBER: D26351
29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Cheley 7700 Old Branch Ave Clinton Md
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Gertha Davidson-Randall

DHMH-16 Rev 1/89

89 29659

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Cornelius HALL III | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 28 / 89 | 3. TIME OF DEATH: 6:30 P M |
| 4. SOCIAL SECURITY NUMBER: 217-72-7928 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 31 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 5/6/58 | 8. BIRTHPLACE (State or Foreign Country): Morocco |
| 9a. FACILITY NAME (If not institution, give street and number): 5819 Fisher RD Apt. 201 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills | | 9c. COUNTY OF DEATH: PG |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: PG | 10c. CITY, TOWN OR LOCATION: Temple Hills | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 5819 Fisher RD. | | 10f. ZIP CODE: 20748 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Correctional Officer | 16b. KIND OF BUSINESS/INDUSTRY: Government | |
| 17. FATHER'S NAME (First, Middle, Last): Cornelius Hall, Jr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Lee Starr | |
| 19a. INFORMANT'S NAME (Type/Print): Cassandra Hall | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5819 Fisher Road, Temple Hills, MD. | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Memorial | 20c. LOCATION — City or Town, State: Suitland, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Stewart, III | | 22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 4001 Benning Rd., N.E. Wash. D.C. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Self inflicted Gun Shot Wound To Head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Linda Whitby MD | 29c. LICENSE NUMBER: D-17162 | 29d. DATE SIGNED (Month, Day, Year): 10/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda Whitby MD 9556 Crain Hwy Upper Marlboro, MD | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use ... the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29660

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| BARBARA HELMICK | | OCTOBER 30, 1989 | 3.00 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-72-5929 | 1 ☐ M 2 ☒ F | 28 YRS. | | | Aug. 12 1961 | MD. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | ------- |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD. | ------ | BALTIMORE | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 4315 CLAREWAY | 21213 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| n/a | n/a | DISABLED | NONE |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM M. HELMICK, SR. | BERNADETTE HULSEY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| WILLIAM M. HELMICK SR.-FATHER | 4315 CLAREWAY BALTIMORE, MD. 21213 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | BALTIMORE CEMETERY | BALTIMORE, MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Brian D Jarvis | SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | ? 1 day |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Recurrent episodes of sepsis ? etiology | 3 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Mental Retardation / Cerebral Palsy | 28 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Recurrent Aspiration Pneumonias ; Bowel infarction | years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Eric M Jarvis, MD | D5733 | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ERIC M JARVIS, MD Johns Hopkins Hosp. Baltimore MD 21205

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julie Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician or attendant for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and retained by the funeral director.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

HELMICK, BARBARA 10/30/89 57 A

89 29660

SEP 18 2 1 '89

89 29661

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and ___ burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ola Jones | | | | | 2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89 | 3. TIME OF DEATH: 6:30 A M |
| 4. SOCIAL SECURITY NUMBER: 295-26-6145 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6 15 30 | 8. BIRTHPLACE (State or Foreign Country): Ala. |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hosp. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. | | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: | | 10c. CITY, TOWN OR LOCATION: Balto. | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3313 Egerton Rd. | | | 10f. ZIP CODE: 21215 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Marshall Anthony | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Flowers | | | |
| 19a. INFORMANT'S NAME (Type/Print): Tia Sujat | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4737 N. 11th St., Arlington, Va. 22205 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cem. | | 20c. LOCATION — City or Town, State: Elksridge, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lola March | | | 22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Ave. | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. mestatic cancer
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
c. non-small cell lung cancer
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J Acosta MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Acosta MD Sinai Hospital, Baltimore, MD

31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29662

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached or used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| John | Henry | KOPP , SR. | October 31 89 | 6:10 a M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-01-5234 | 1 [X] M 2 [ ] F | 91 YRS. | | | NOV. 15, 1898 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| FRANKLIN SQUARE HOSPITAL | | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE | BALTIMORE | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 4318 SOTH AVENUE | 21236 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO — WWI | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| N/A | N/A | MACHINIST | CROWN CORK AND SEAL |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JOHN S. KOPP | MARY NEUSCHAEFER |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOHN H. KOPP , JR. (SON) | 2744 E. BALTIMORE STREET, BALTIMORE, MARYLAND 21224 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | MOST HOLY REDEEMER CEMETERY | BALTIMORE, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ John F. Collins | SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD BALTIMORE, MARYLAND 21236 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Atherosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Chronic Obstructive Pulmonary Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Senile Dementia, Status Post Cerebrovascular Accident

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Joyce E. King MD | | ▶ 10/31/89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) | |
|---|---|
| JOYCE E. KING, M.D. | 9000 Franklin Square Dr., Baltimore 21237 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 21 1989 | Gisha Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the ___ the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary Angela Kroen | | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 31 / 89 | 3. TIME OF DEATH: 10 46 PM |
| 4. SOCIAL SECURITY NUMBER: 214-56-7307 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 34 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): 10-8-55 | 8. BIRTHPLACE (State or Foreign Country): Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Stella Maris Hospice | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Md. | | 9c. COUNTY OF DEATH: Balto. Co. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: ----- | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3510 LYNCHESTER RD. | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): n/a | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: ------ | |
| 17. FATHER'S NAME (First, Middle, Last): THOMAS G. KROEN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HAZEL M. UNROE | |
| 19a. INFORMANT'S NAME (Type/Print): HAZEL KROEN (MOTHER) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1948 SEARLES RD., BALTIMORE, MD. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY | 20c. LOCATION — City or Town, State: BALTIMORE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian D. Lewis | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 9705 Belair Rd., Balto. Md. 21236 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Astrocytoma Grade III

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Metastatic disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospice

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURRED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: 23504

29d. DATE SIGNED (Month, Day, Year): ▶ 10-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. E. Takeuda MD 2300 Delaney Valley Rd. Towson md. 21204

31. DATE FILED (Month, Day, Year): NOV 2 1989

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

OHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DR IMRE Kopits / IMRE KOPITS
2. DATE OF DEATH (Month, Day, Year): 10 29 '89
3. TIME OF DEATH: 1:20 PM M
4. SOCIAL SECURITY NUMBER: 103-32-3849
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-15-01
8. BIRTHPLACE (State or Foreign Country): HUNGARY
9a. FACILITY NAME (If not institution, give street and number): Stella Maris
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: BALTO

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 14 W. Coldspring Lane
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 8
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Doctor
16b. KIND OF BUSINESS/INDUSTRY: Medical
17. FATHER'S NAME (First, Middle, Last): Eugene Kopits
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lugza Muller
19a. INFORMANT'S NAME (Type/Print): Dr. Steven E. Kopits
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5212 St. Albans Way, Balto., Md. 21212
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory 11/2/89
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ronald C. Schaefer Jr.
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | 1) a. PARKINSON'S DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | 3) b. Adv. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | 2) c. Ca. of Prostate | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D 14506
29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eddie NAKhuda MD / 2300 Dulaney Valley Rd. 21204
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 29665

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital, attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN L. MAVOR | | | 2. DATE OF DEATH (Month, Day, Year): OCT 31 89 | 3. TIME OF DEATH: 655 PM |
| 4. SOCIAL SECURITY NUMBER: 213-07-5526 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 18, 1899 | 8. BIRTHPLACE (State or Foreign Country): Scotland |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE COUNTY | 10c. CITY, TOWN OR LOCATION: Dundalk | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7232 GERMAN HILL RD (1946 Midland Road) MERIDIAN NURSING | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY: Beth Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Mavor | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Moir | |
| 19a. INFORMANT'S NAME (Type/Print): Gilbert Mavor | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1946 Midland Road Baltimore MAryland 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith Cemetery | 20c. LOCATION — City or Town, State: Rossville MAryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home of Dundalk 21222 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PNEUMONIA.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DIABETES
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DEMENTIA
PROSTATIC CANCER.
CEREBROVASCULAR ACCIDENT

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | | 29c. LICENSE NUMBER: D37233 | 29d. DATE SIGNED (Month, Day, Year): ▶ Oct 31 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH HUBAYKAH. CHURCH HOSPITAL CORPORATION | | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

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MALINOW, CHARLES L
10/07/26 89 29666

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

RELEASED AS NON-MED PER MR. LAWYER & DR. GOLLE
DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES L. MALINOW | | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 1989 | 3. TIME OF DEATH: 1:26 A M |
| 4. SOCIAL SECURITY NUMBER: 218-22-6601 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10 7 1926 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: CITY | |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Randallstown | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 3618 Briarstone Rd. | | 10f. ZIP CODE: 21133 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW 2 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Engineer & Rep. | | | 16b. KIND OF BUSINESS/INDUSTRY: Electronic | |
| 17. FATHER'S NAME (First, Middle, Last): Harry Malinow | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Weinberg | |
| 19a. INFORMANT'S NAME (Type/Print): Helene Malinow | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3618 Briarstone Rd., Randallstown, MD 21133 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Aitz Chaim Cemetery | | | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Mazzulla | | | | | 22. NAME AND ADDRESS OF FACILITY: Hebrew Memorial Funeral Home, Inc. 1100 Reisterstown Road, Pikesville, MD | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Ventricular Tachycardia. | 2 hrs. |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Myocardial Infarction. | 5 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Peripheral Vascular Disease | 2 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): d. | Diabetes | 10 yrs. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [/] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [/] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [/] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |
|---|---|---|
| | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bruce R Conklin MD, Johns Hopkins Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 10/31/1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29667

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use of the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE S. MIHALOS
2. DATE OF DEATH (Month, Day, Year): October 30, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 220-20-3891
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 60 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 24, 1929
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 3399 Liberty Gardens Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3399 Liberty Gardens Rd.
10f. ZIP CODE: 21207
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Restuarant Owner
16b. KIND OF BUSINESS/INDUSTRY: Windsor Inn

17. FATHER'S NAME (First, Middle, Last): Stamatis G. Mihalos
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sophia J. Psychia

19a. INFORMANT'S NAME (Type/Print): Jean L. Mihalos
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10

20a. METHOD OF DISPOSITION: [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greek Orthodox Cemetery 11-2-89
20c. LOCATION — City or Town, State: Balto., Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wallace S. Brooks Jr.
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hepatic Failure + bowel distruction | 1 month |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Metastatic Colon Cancer | 2 yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Wm C Waterfield MD
29c. LICENSE NUMBER: 024356
29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William C. Waterfield, M.D., 900 Caton Ave., Catonsville, Md. 21229
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Registrar

ONMN-18 Rev 1/89

89 29667

89 29668

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH Month / Day / Year | | | 3. TIME OF DEATH |
| Ella | Lucinda | Moessbauer | | Oct. | 31 | 1989 | M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTHPLACE (State or Foreign Country) |
| 216-03-9854 | 1 ☐ M 2 ☒ F | 96 YRS. | | | June 20 | 1893 | Maryland |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
| Villa St. Michael | Baltimore | - |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
| Maryland | - | Baltimore | 1 ☒ YES 2 ☐ NO |

| | | |
|---|---|---|
| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
| 4800 Seton Drive | 21215 | USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Interior Decorator | H. Chambers Co. |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| Joseph Watts | Ella Louise Thawley |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| David T. Moessbauer | 3016 Moores Rd., Baldwin, Md. 21013 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| | Metro Crematory | Baltimore, Maryland |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
| ▶ Bryan W. Clary Bryan W. Clary | Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. GASTRO-INTESTINAL BLEEDING
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CEREBRAL THROMBOSIS

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28d. DESCRIBE HOW INJURY OCCURRED |
| | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
| Tasneem Lakhani MD | D28595 | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Tasneem Lakhani, M.D. , 7220 Park Heights Ave., Balto., Md. 21208

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
| NOV 2 1989 | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to out-of-state transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lillian F. Mathison | | | | | 2. DATE OF DEATH (Month, Day, Year): NOV. 01, 1989 | 3. TIME OF |
| 4. SOCIAL SECURITY NUMBER: 216-12-6473 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/25/14 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 5810 Oakland Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Halethorpe | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Halethorpe | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5810 Oakland Road | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): ------ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): operator | 16b. KIND OF BUSINESS/INDUSTRY: restaurant | |
| 17. FATHER'S NAME (First, Middle, Last): Peter Kemp | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Brick | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Turner Mathison | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5810 Oakland Road Halethorpe Md 21227 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore National Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY: AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD, ARBUTUS, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hepatic Failure | 2 wks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Metastases from carcinoid tumor | 6 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William C Waterfield MD | D24356 | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William C Waterfield MD — St Agnes Hospital 900 Caton Ave Balt Md 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) RUTH ANNA NORRIS / RUTH A. NORRIS | | | | | 2. DATE OF DEATH MONTH 10 DAY 30 YEAR 89 | 3. TIME OF DEATH 6 45 A M |
| 4. SOCIAL SECURITY NUMBER 214-03-1935 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) Aug. 25, 1910 | 8. BIRTHPLACE (State or Foreign Country) Maryland |
| 9a. FACILITY NAME (If not institution, give street and number) Keswick Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore | | | 9c. COUNTY OF DEATH |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE Maryland | 10b. COUNTY Harford | | 10c. CITY, TOWN OR LOCATION Bel Air | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER 109 Donzen Dr., Apt. E | | | 10f. ZIP CODE 21014 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 8+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary | | 16b. KIND OF BUSINESS/INDUSTRY Proctor & Gamble | |
| 17. FATHER'S NAME (First, Middle, Last) Frank B. Norris, Sr. | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Elva N. Gehr | | | |
| 19a. INFORMANT'S NAME (Type/Print) Zula D. Norris | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10 | | | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 11/2/89 | | 20c. LOCATION — City or Town, State Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ [signature] | | | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction, acute | hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic heart disease | years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D12957 | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Phillip Moore, M.D.,

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | [signature] |

DHMH-16 Rev 1/89

89 29670

89 29671

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be restriped by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 is the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Darren B. Parham | | | | 2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89 | 3. TIME OF DEATH: 1:16 P M |
| 4. SOCIAL SECURITY NUMBER: 213-84-1280 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 24 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-21-65 | 8. BIRTHPLACE (State or Foreign Country): RICHMOND, VA |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 518 N. GILMORE STREET | | | 10f. ZIP CODE: 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | | 16b. KIND OF BUSINESS/INDUSTRY: UNITED IRON & METAL | |
| 17. FATHER'S NAME (First, Middle, Last): LEE PARHAM | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE JARRATT | | |
| 19a. INFORMANT'S NAME (Type/Print): ANNIE PARHAM | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 518 N. GILMORE/BALTIMORE, MD 21223 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ZION UNION APOSTALIC CH CEM | | 20c. LOCATION — City or Town, State: LAWRENCEVILLE, VA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Francis [illegible] | | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Cocaine Intoxication
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): est. 10/24/89
28b. TIME OF INJURY: Unk. M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: Unknown
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Unknown
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Unknown

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr. M.D.
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201

31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29672

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Latoya Ann Patterson | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 89 | 3. TIME OF DEATH: 6:50 A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): YRS. | IF UNDER 1 YEAR: MONTHS 3, DAYS; IF UNDER 24 HRS.: HOURS, MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-02-89 |
| 8. BIRTHPLACE (State or Foreign Country): PHILA., PA. | | | | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: N/A | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: PA. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: PHELIDELPHIA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2448 NORTH CLEVELAND AVENUE | 10f. ZIP CODE: | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BABY | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM N. PATTERSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SHIRLEY A. PATTERSON | |
| 19a. INFORMANT'S NAME (Type/Print): WILLIAM PATTERSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2448 NORTH CLEVELAND AVENUE | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOUNT PEACE CEMETERY | 20c. LOCATION — City or Town, State: PHILA., PA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lynette K. Jones | | 22. NAME AND ADDRESS OF FACILITY: BROWN/THOMPSON F.H. P.O. BOX 4433 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Anoxic encephalopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Obstruction of airway and compression | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10/27/89 | 28b. TIME OF INJURY: 12:15A M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: Alledged overlaying by sibling | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road (in auto) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): I-95 north of Caron Ave, Balto, MD | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Frank J. Peretti, M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 10/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank J. Peretti, M.D. - Assistant | 111 Penn St. | Balto.MD. |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson | |

OHMH-16 Rev 1/89

89 29673

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Delores | J. | Porter | 10 28 89 | 12:46 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 216-42-6680 | 1 ☐ M 2 ☒ F | 44 YRS. | | | 8 8 45 | Va. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| University Hospital | Baltimore | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | | Balto. | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 529 W. Mosher St. | 21217 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Constant Care Health Care | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Dawson Eley | Gladys Porter |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Jacqueline Brown | 3654 Paskin Place 21207 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Arbutus Mem Park | Balto. County |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Dola March | March Funeral Home 4300 Wabash AVe. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive & arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto.MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29674

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clementine Powell — CLEMENTINE P. POWELL
2. DATE OF DEATH (Month, Day, Year): 10-30-89 — 10 30 89
3. TIME OF DEATH: 8:00 PM
4. SOCIAL SECURITY NUMBER: 217-16-4749
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 88 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/27/01
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Meridan Nursing Home-Frederick, Meridan Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick Frederick
9c. COUNTY OF DEATH: Frederick Frederick

RESIDENCE OF DECEDENT

10a. STATE: Md. Maryland
10b. COUNTY: Frederick Frederick
10c. CITY, TOWN OR LOCATION: Frederick Frederick
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: ~~Rt 9 Box 34~~ 7475 Betsy Ross Dr. Frederick, Md.
10f. ZIP CODE: 21701 21701
10g. CITIZEN OF WHAT COUNTRY? U.S U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): Charles Priess
18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Schaeffer
19a. INFORMANT'S NAME (Type/Print): John K. Powell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 785 Long Corner Rd.-Mt.Airy, Md. 21771
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____ — 10-31-89
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery
20c. LOCATION — City or Town, State: Balto., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C. Truman Schwab
22. NAME AND ADDRESS OF FACILITY: 3512 Frederick Ave. Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
pernicious anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas E Stone
29c. LICENSE NUMBER: D 11312
29d. DATE SIGNED (Month, Day, Year): ▶ 10-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas STONE 4 West 3rd St Frederick MD
31. DATE FILED (Month, Day, Year): NOV 21989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

89 29571

89 29675

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUISE GRACE PERSSON
2. DATE OF DEATH (Month, Day, Year): 10 26 89
3. TIME OF DEATH: 330 A M
4. SOCIAL SECURITY NUMBER: 213-14-3968
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): FEB. 18 1902
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): FRANCES SCOTT KEY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: ------

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: ----
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1117 BUNBURY WAY
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a — College (1-4 or 5+): n/a
16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ASSEMBLY LINE
16b. KIND OF BUSINESS/INDUSTRY: PACKING HOUSE
17. FATHER'S NAME (First, Middle, Last): LORENZO WILKERSON
18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN
19a. INFORMANT'S NAME (Type/Print): MARY B. BAILEY (DGHTR)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1126 QUANTRIL WAY BALTIMORE MD. 21205
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BOHEMIAN NATIONAL
20c. LOCATION — City or Town, State: BALTIMORE MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Uro sepsis | 2 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Alison Molterno MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALYSON MOLTERNO MD Frances Scott Key Medical Center 5950 Eastern Ave Balto MD
31. DATE FILED (Month, Day, Year): 10/26 NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29215

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the [illegible] attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH G. PERNITSCH | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 6:30 A M |
| 4. SOCIAL SECURITY NUMBER: 212-07-1401 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 06 23 14 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 1632 JEFFERS ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: TOWSON | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1632 JEFFERS ROAD | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 2 YRS. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ACCOUNTANT | 16b. KIND OF BUSINESS/INDUSTRY: STATE OF MARYLAND |
| 17. FATHER'S NAME (First, Middle, Last): GABRIAL PERNITSCH | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): OLGA SPOLERICH | |
| 19a. INFORMANT'S NAME (Type/Print): MARGARET PERNITSCH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1632 JEFFERS ROAD, TOWSON, MARYLAND 21204 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A. Alan Seitz, Jr | | 22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Atherosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertension | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Anemia of uncertain etiology

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Carl Sperling MD | 29c. LICENSE NUMBER: D28987 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CARL SPERLING MD 302 E. 33RD ST. BALTO MD 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): P. Frances Rosenfeld | | | 2. DATE OF DEATH (Month, Day, Year): October 23, 1989 | 3. TIME OF DEATH: 12:30 PM |
| 4. SOCIAL SECURITY NUMBER: 212-07-8223 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 02/22/07 | 8. BIRTHPLACE (State or Foreign Country): Brooklyn, N.Y. |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: N/A |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 417 Waveland Rd.-Balto., Md. | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY? U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: N/A | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: N/A | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: N/A |
| 17. FATHER'S NAME (First, Middle, Last): George E. Phillips | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Jessie A. Rhoads | |
| 19a. INFORMANT'S NAME (Type/Print): David Winyard | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1032 Mountain Top Dr.-Annapolis, Md. #21401 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-26-89 Entombment | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Pk. Cemetery | 20c. LOCATION — City or Town, State: Balto., Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: G. Truman Schwab | | 22. NAME AND ADDRESS OF FACILITY: 5151 Baltimore National Pike Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adenocarcinoma of the Lung (TERMINAL) | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jamal Abdel-Halim | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMAL ABDEL-HALIM, M.D. C/O Maryland General Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Davidson-Kendall |

DHMH-16 Rev 1/89

89 29678

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Prentiss Eldon Rowe | | 2. DATE OF DEATH (Month, Day, Year): 10 29 89 | 3. TIME OF DEATH: 1606 M |
| 4. SOCIAL SECURITY NUMBER: 442-20-9347 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-5-23 |
| 8. BIRTHPLACE (State or Foreign Country): OKLAHOMA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adv. Hosp. | 9b. CITY, TOWN OR LOCATION OF DEATH: Rockville MD | 9c. COUNTY OF DEATH: Mont. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: GAITHERSBURG | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 9 MISTY DALE WAY | | 10f. ZIP CODE: 20877 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYED ACTOR | 16b. KIND OF BUSINESS/INDUSTRY: ENTERTAINMENT |
| 17. FATHER'S NAME (First, Middle, Last): PRENTISS ELDON ROWE SR. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | |
| 19a. INFORMANT'S NAME (Type/Print): JOANN ROWE (spouse) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 MISTYDALE WAY, GAITHERSBURG, MD. 20877 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald W Wade 11-1-89 | | 22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Possible Cardiac arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Possible Acute Myocardial infarction | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Hena Khaney | 29c. LICENSE NUMBER: D22978 | 29d. DATE SIGNED (Month, Day, Year): 10/31/89 AM |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 19520 Doctors Drive, Germantown, MD 20874 | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall DR-KHIANEY | |

DHMH-16 Rev 1/89

Item 15 11-9-89 Film G657 W.H. Per F/H

89 29679

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be forwarded for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified before**

6

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HELEN RITTER | | | | 2. DATE OF DEATH (Month - Day - Year): 10 - 29 - 89 | 3. TIME OF DEATH: 3:05 AM |
| 4. SOCIAL SECURITY NUMBER: 217-20-9419 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8/9/1904 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hospital, INC. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: ------- | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2211 W. Rogers Avenue | | 10f. ZIP CODE: 21209 | | 10g. CITIZEN OF WHAT COUNTRY: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerical Worker | 16b. KIND OF BUSINESS/INDUSTRY: Manufacturing Co. | | | |
| 17. FATHER'S NAME (First, Middle, Last): Gilbert R. Younger | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Pearce | | | |
| 19a. INFORMANT'S NAME (Type/Print): Doris Ensminger | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2810 Falls Mont Drive Fallston, MD 21047 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley | | 20c. LOCATION — City or Town, State: Cockeysville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Walter Henss | | 22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home, 3631 Falls Road Baltimore, MD 21211 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CA of URINARY BLADDER, METASTATIC

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

Permission for limited autopsy obtained after certificate signed

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | M | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| (SURGICAL H.O.) | D-24710 | ▶ 10-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARMANDO A. REAL, MD (ST. JOSEPH HOSP 7620 YORK RD. Md 21204).

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29680

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Bernard W. Ritterpusch
2. DATE OF DEATH: MONTH 10 DAY 26 YEAR 89
3. TIME OF DEATH: 7:45 PM
4. SOCIAL SECURITY NUMBER: 215-07-0065
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 05-10-08
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist NTH
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: ROCKVILLE
10c. CITY, TOWN OR LOCATION: DARNESTOWN
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 13424 SCOTTISH AUTUMN LANE
10f. ZIP CODE: 20878
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a College (1-4 or 5+): n/a
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AGENT
16b. KIND OF BUSINESS/INDUSTRY: LIFE INSURANCE
17. FATHER'S NAME (First, Middle, Last): JOHN RITTERPUSCH
16. MOTHER'S NAME (First, Middle, Maiden Surname): MARY LANAHAN
19a. INFORMANT'S NAME (Type/Print): MARY E. HARTMAN (DGHTR)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9-C PIPE HILL COURT BALTO. MD. 21209
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOLY REDEEMER CEMETERY
20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eugene J. Lantner Jr
22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Balto. Md. 21213

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Aspiration Pneumonia | Days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Recurrent Transient ischemic attacks | Months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Generalized atherosclerotic vascular disease | Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Progressive dementia associated with Parkinson disease
Chronic hypertension, Atrial tachycarrhythmias
Vitamin B12 deficiency.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 6 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Byrl O. Johnson M.D.
29c. LICENSE NUMBER: 0-19042
29d. DATE SIGNED (Month, Day, Year): ▶ 10/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BYRL O. JOHNSON 911 N. Russell Ave. Gaithersburg, Maryland 20879
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the funeral director or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29681

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THOMAS John RISINGER | | | 2. DATE OF DEATH (Month, Day, Year): October 30, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 076-18-9927 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8-25-1921 | 8. BIRTHPLACE (State or Foreign Country): N.Y. |
| 9a. FACILITY NAME (If not institution, give street and number): 3604 Bellevale Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3604 Bellevale Ave. | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Yrs. / College (1-4 or 6+): 3 Yrs. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor | 16b. KIND OF BUSINESS/INDUSTRY: Central Supply Johns Hopkins Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): William S. Risinger | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Williams | |
| 19a. INFORMANT'S NAME (Type/Print): Lesley F. Faber | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5825 Lagorce Dr., Miami Beach, Fla. 33140 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery 11-2-89 | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Roy H. Cather (Roy H. Cather) | | 22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford RD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the moda of dying, such ss cardiac or respiratory srrest, shock, or hesrt failure. Liat only one cause on sech iins.

| | | Approximate interval Between Onset snd Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disesse or condition resulting in death) → a. | Cardiac Arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Acute myocardial infarction | 16 days |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 6 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
[X] 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
[ ] 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dus to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: DA12378 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Wyman Wong, M.D. 6801 Belair Rd. | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Gertrude Davidson-Randall | |

DHMH-16 Rev 1/89

89 29681

89 29682

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| ALBERT | FRANCIS | SIMMONS | 10 / 31 / 89 | 8:30 PM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 224-12-3904 | 1 [X] M 2 [ ] F | 75 YRS. | | | 8-21-14 | VA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| UNION MEMORIAL HOSPITAL | BALTIMORE CITY | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2602 CECIL AVENUE | 21218 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondery (0-12) | College (1-4 or 5+) | | |
| 4th | | CRANE OPERATOR | BETHLEHEM STEEL |

| 17. FATNER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JAMES SIMMONS | RUTH ANN MOORE |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ALMA SIMMONS | 2602 CECIL AVENUE/BALTIMORE, MD 21218 |

| 20a. METNOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | MACEDONIA BAPT CHURCH CEMETERY | GREENSVILLE, VA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Francis [illegible] | WM. C. MARCH F/H 1101 E. NORTH AVENUE |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | 1 W |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Aspiration | Same |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Encephalopath | Same |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Hypoxia | Same |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic lung disease, Chronic heart failure, Hypoglycemia, ETOH abuse.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined | NA | NA M | 1 [ ] YES 2 [ ] NO NA | NA |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| NA | NA |

29a. CERTIFIER (Check only one)

1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [illegible] Harake RII | | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Mayer El-Harake MD

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29682

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO. 89-29683

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Daniel L SIEGER Sr. | | | | 2. DATE OF DEATH (Month, Day, Year): Oct. 26, 1989 | 3. TIME OF DEATH: 9:40 p.m |
| 4. SOCIAL SECURITY NUMBER: 218-05-5574 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): DEC. 24, 1920 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 9526 PERRY HALL BOULEVARD, APARTMENT 203 | | 10f. ZIP CODE: 21236 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MILLWRIGHT | 16b. KIND OF BUSINESS/INDUSTRY: STEEL MILL |
| 17. FATHER'S NAME (First, Middle, Last): RALPH C. SIEGER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): NANCY LAMONT | |
| 19a. INFORMANT'S NAME (Type/Print): MINNIE L. SIEGER (WIFE) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9526 PERRY HALL BOULEVARD, APARTMENT 203, BALTIMORE, MARYLAND 21236 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BELAIR MEMORIAL GARDENS | 20c. LOCATION — City or Town, State: BEL AIR, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John F. Collins | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory Failure.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic Lung Carcinoma.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: [X] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: PGY-1 | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): 10/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Peter Lopresti M.D. 9000 Franklin Square Dr. Baltimore 21237.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Jane Davidson-Randall |

OHMH-16 Rev 1/89

89-29684

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GRANVILLE J. SLYE, SR. | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 11:52 P M |
| 4. SOCIAL SECURITY NUMBER: 215-07-4325 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 7, 1909 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Greater Laurel/Beltsville Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: Prince George |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George | 10c. CITY, TOWN OR LOCATION: Beltsville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4911 Powder Mill Road | | 10f. ZIP CODE: 20705 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 years; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister | 16b. KIND OF BUSINESS/INDUSTRY: Religion | |
| 17. FATHER'S NAME (First, Middle, Last): Clyde Casper Slye | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Susan Canney | |
| 19a. INFORMANT'S NAME (Type/Print): Granville J. Slye, JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 817 Montgomery Street Laurel, Maryland 20707 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery | 20c. LOCATION — City or Town, State: Adelphi, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald V. Borgwardt | | 22. NAME AND ADDRESS OF FACILITY: Borgwardt Funeral Home 4400 Powder Mill Rd. Beltsville, Md. 20705 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC RENAL CARCINOMA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I: PROSTATIC CARCINOMA, CONGESTIVE HEART FAILURE MYOCARDIAL ISCHEMIA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D24035 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ESMACHADO 321 PRINCE GEORGE ST LAUREL MD | | |
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21208-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached hereto as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29685

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Phillip Sudano — PHILIP ANTHONY SUDANO SR. | | | | 2. DATE OF DEATH (Month, Day, Year): OCT. 31, 1989 | 3. TIME OF DEATH: 1145 AM M |
| 4. SOCIAL SECURITY NUMBER: 217-24-0400 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 58 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JAN. 17, 1931 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: WHITE MARSH | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5725 CARRINGTON DRIVE | | 10f. ZIP CODE: 21162 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: KOREAN | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CAR SALESMAN | 16b. KIND OF BUSINESS/INDUSTRY: AUTOMOBILE | |
| 17. FATHER'S NAME (First, Middle, Last): ORAZIO SUDANO | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH VINCI | |
| 19a. INFORMANT'S NAME (Type/Print): ROSALIE C. SUDANO (WIFE) | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5725 CARRINGTON DRIVE, WHITE MARSH, MARYLAND 21162 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John F. Schimunek | | 22. NAME AND ADDRESS OF FACILITY: SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD BALTIMORE, MARYLAND 21236 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | e. Pneumonia — DUE TO (OR AS A CONSEQUENCE OF): | 3 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. adenocarcinoma of lung — DUE TO (OR AS A CONSEQUENCE OF): | 1 month |
| | c. adenocarcinoma of colon — DUE TO (OR AS A CONSEQUENCE OF): | 6 months |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Alan Schneider | 29c. LICENSE NUMBER: pending | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alan Schneider 301 St Paul St Baltimore MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 2 1989 | 32. REGISTRAR'S SIGNATURE: Freda Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29686

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES H. SOLLERS — James H. Sollers
2. DATE OF DEATH (Month, Day, Year): 10 27 89
3. TIME OF DEATH: 5:31 AM
4. SOCIAL SECURITY NUMBER: 215-07-7144
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/05/15
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Fallston General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: FALLSTON
9c. COUNTY OF DEATH: HARFORD

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Kingsville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 6605 Mt. Vista Rd.
10f. ZIP CODE: 21087
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman
16b. KIND OF BUSINESS/INDUSTRY: Bendix Corp.
17. FATHER'S NAME (First, Middle, Last): Basil Sollers
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Garrish
19a. INFORMANT'S NAME (Type/Print): Charles R. Eck
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 521 W. Belair Ave., Aberdeen, Md. 21001
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Mem.Gdns.10/31/89
20c. LOCATION — City or Town, State: Timonium, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. massive stroke | 4 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASCVD. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEOICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D 21207
29d. DATE SIGNED (Month, Day, Year) ▶ 10/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): F. VELCA CAMILLERI, MD 827 LINDEN AVE BALTO MD 21201
31. DATE FILED (Month, Day, Year): NOV 2/1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29687

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Eva Elizabeth SISKE | | | | | 2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89 | 3. TIME OF DEATH: 9:35 A M |
| 4. SOCIAL SECURITY NUMBER: 215-12-0729 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/20/04 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1223 Birch Avenue | | | 10f. ZIP CODE: 21227 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. OECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 yrs. College (1-4 or 5+): -------- | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): seamstress | | 16b. KIND OF BUSINESS/INDUSTRY: clothing | |
| 17. FATHER'S NAME (First, Middle, Last): Edward Hartman | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Paul | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Earl Hartman | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2645 Wilkens Avenue 21223 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | | 20c. LOCATION — City or Town, State: Dorsey, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, Md. 21227 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic Cardiovascular Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO X Inspection | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle Jr. M.D. | OCME | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 vl

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

OHMH-16 Rev 1/89

ITEMS:11,16a per FH G-659
1-17-90 cm

89 29688

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James W. Thomas
2. DATE OF DEATH (Month, Day, Year): Oct 28 1989
3. TIME OF DEATH: 2 47 P.M.
4. SOCIAL SECURITY NUMBER: 216-36-4039
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 50 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-27-39
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4611 Pen Lucy Rd Apt B
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): AUTO MECHANIC
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): James W. Thomas
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Henry
19a. INFORMANT'S NAME (Type/Print): Gregory Thomas
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4611 Pen Lucy Apt B Balto, Md 21229
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery
20c. LOCATION — City or Town, State: Balto, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale March
22. NAME AND ADDRESS OF FACILITY: March F.H. West 7300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute Myocardial Infarction — Immediate

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 5 [ ] Could not be determined
25a. DATE OF INJURY (Month, Day, Year):
25b. TIME OF INJURY: M
26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED:
25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stanley Felsenberg MD Deputy Medical Examiner
29c. LICENSE NUMBER: D01085
29d. DATE SIGNED (Month, Day, Year): OCT 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY Z. FELSENBERG MD 11 E. Chase St 21202
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 29689

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146 BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Trimble, Theresa
2. DATE OF DEATH: MONTH 10 DAY 28 YEAR 89
3. TIME OF DEATH: 8:15 PM
4. SOCIAL SECURITY NUMBER: 217-03-5353
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/9/11
8. BIRTHPLACE (State or Foreign Country): Colorado
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: ---------

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ---------
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1309 W. 40th Street
10f. ZIP CODE: 21211
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Production Worker
16b. KIND OF BUSINESS/INDUSTRY: Food Manufacture
17. FATHER'S NAME (First, Middle, Last): Joseph Guercio
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Carnegio
19a. INFORMANT'S NAME (Type/Print): Raymond A. Trimble
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1309 W. 40th Street Baltimore, MD 21211
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Grace Methodist Cem.
20c. LOCATION — City or Town, State: Cockeysville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Walter Henss
22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Massive cerebral hemorrhage — <24°

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Tamara H. Abbas MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 10-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TAMARA H. ABBAS UNION MEM. HOSP. 201 E UNIV PKWY BALTIMORE MD 21218
31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with... after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

89 29690

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the funeral or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SEBETTA WARREN
2. DATE OF DEATH (Month, Day, Year): 10 28 89
3. TIME OF DEATH: 1.10 pm
4. SOCIAL SECURITY NUMBER: 219-32-0179
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-15-03
8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAC CTR
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMRE
9c. COUNTY OF DEATH: MD

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3915 CALLOWAY AVE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Thomas Claibourne
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lelia Pettis

19a. INFORMANT'S NAME (Type/Print): Julius Warren, Jr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9066 Dunloggin Rd., Ellicott City, Md. 21043

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Cem.
20c. LOCATION — City or Town, State: Elksridge, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale March
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CONGESTIVE CARDIAL FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. MYOCARDIAL INFARCTION. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Neil Kamel MD
29c. LICENSE NUMBER: D36409
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): NOV 2 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 25590

89 29691

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donyea Tamein WALKER | | | | 2. DATE OF DEATH (Month, Day, Year): 10 / 30 / 89 | 3. TIME OF DEATH: 10:00 P M |
| 4. SOCIAL SECURITY NUMBER: 217-84-4929 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 15 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 5-3-74 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital (STU) | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTO | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 701 Edgewood St | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Negro |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) ◯ / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student | 16b. KIND OF BUSINESS/INDUSTRY: — | |
| 17. FATHER'S NAME (First, Middle, Last): Linwood J.D. WALKER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Tangi Williams | | |
| 19a. INFORMANT'S NAME (Type/Print): Linwood WALKER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1939 W. Baltimore St. Balto MD 21223 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Balto. cem. | 20c. LOCATION — City or Town, State: Balto. MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Betts Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 1129 N. Caroline St. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gunshot wound to head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10/29/89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject shot |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 700 blk. of Linnard St., Baltimore City |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle, Jr. M.D. | OCME | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 vl

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 2691

89 29692

Items:23 thru 28f per ME G-657
11-17-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Smithie | JANE | Whitley | 10-29-89 | 10:25AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219-20-8298 | 1 ☐ M 2 ☒ F | 75 YRS. | | | 3-28-1914 | NORTH CARLINA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| University Hospital | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| M.D. | | BALTIMORE | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3209 Burning Well Rd | 21207 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| 12 | | SEAMSTRESS | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James CAPEHART | Smithie Allen |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Catherine Whitley | 4009 Cedardale Rd Balto. M.D. 21215 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Woodlawn Cemetery | Balto. M.D. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Genevieve L. Redd | Redd Funeral Service 1721 N. Monroe St. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each line.

| | | Approximete Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Acute and chronic subdural hematoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX 1 ☐ YES 2 ☐ NO | XX 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 28. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XXX 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient XX 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | UNKNOWN | M | 1 ☐ YES 2 ☒ NO | SUBJECT FELL |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| HOME | 3209 Burning Well Rd. Baltimore City, Maryland |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 10-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 2962

89 29693

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. for use as the burial-transit permit. Pages 1, 2, 3 should
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIE M. WALSTRUM / Marie M. Walstrum | | | 2. DATE OF DEATH (Month, Day, Year): Oct. 28 1989 | 3. TIME OF DEATH: 9:25 PM |
| 4. SOCIAL SECURITY NUMBER: 220-38-6846 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 14,1897 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace | 9c. COUNTY OF DEATH: Harford | | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Harford | Forest Hill | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2913 Smithson Dr. | 21050 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | Homemaker | Own Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Peter Wehr | Maude Cope |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Alice Vogtman | same as #10 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | Baltimore Cemetery 11/1/89 | Balto., Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Earl L. Cragg | Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Decompensation | 10 days |
| | DUE TO (OR AS A CONSEQUENCE OF): b. A.S.C.V.D. | ? years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): c. Senility | ? |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

C.O.P.D.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Edward C. Loo, M.D. | | ▶ 10/29/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward C. Loo, M.D., Havre de Grace, Md. 21078

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 2 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

89 2e93

Item #6 per FH sp

89 29694

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| Alvin James | BETTERSON | | 10 / 31 / 89 | 11:58 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 439-10-1859 | 1 [X] M 2 [ ] F | ~~68~~ 67 YRS. | | | 11/17/21 | LOUISIANA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Fallston General Hospital | Fallston | Harford |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | HARFORD CO. | | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2003 WATERGATE COURT | 21040 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM BETTERSON | LUCINDA BETTERSON |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| YVONNE S. BETTERSON | 2003 WATERGATE CT.: EDGEWOOD, MD 21040 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | GARRISON FOREST CEMETERY | OWINGS MILL, MD. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Leroy O. Dyett | LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Multiple Injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Cardiovascular Disease

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 10/31/89 | M | 1 [ ] YES 2 [X] NO | Driver in auto/auto impact |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| road | Rt. 24 & Tollgate Road Harford County, MD |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Frank J. Peretti, MD | OCME | ▶ 11/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Frank J. Peretti, M.D. 111 Penn Street, Baltimore, MD 21201 vl

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DNMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

09 2959

ITEM #6&7 FILM #G657 PER: F. H. 11/06/89 J. A.
Items:23thru 28f per ME G-657
UNK.#89-197 11-29-89 cm

89 29695

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| VANCE | O. | BALTIMORE, JR. | 10 / 26 / 89 | 2:25 P. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-42-5504 | 1 M 2 F | 44 YRS. | | | 8-6-45 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| found in woods in 400 blk. Wyman Park Drive | Baltimore | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | | BALTIMORE CITY | 1 YES 2 NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 333 East Twenty Street | 21218 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 YES 2 NO | 1 YES 2 NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12th Grade | | MECHANIC | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| VANCE O. BALTIMORE SR. | BETTY HOLDEN |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| CLIFTON BALTIMORE | 70 ERVING DRIVE/REISGERTOWN, MD 21136 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | GARRISON FOREST VET, CEM | OWINGS MILLS, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Calvin L. Williams | WM.C. MARCH F.H. 1101 E. NORTH AVE. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Positional Asphyxia complicating Acute Alcohol | |
| | DUE TO (OR AS A CONSEQUENCE OF): Intoxication | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 X YES 2 NO | 1 YES 2 NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 X YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home 5 Residence 6 X Other (Specify) scene |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | UNKNOWN | M | 1 YES 2 X NO | Subject fell down an embankment |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| woods 400 blk Wyman Park in | 400 blk Wyman Park Baltimore, Maryland |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle, Jr. M.D. | OCME | 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
Mario F. Golle, Jr., M.D. 111 Penn St., Balto., Md. 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29695

ITEMS:23,27 per ME' G-659
1-16-90 cm

89 29696

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Kerry M. Battle | | | | 2. DATE OF DEATH (Month, Day, Year): 10 27 89 | 3. TIME OF DEATH: 3:47 P M |
| 4. SOCIAL SECURITY NUMBER: 217-74-2905 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 27 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): 12-11-61 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7210 JIMROW COURT | | 10f. ZIP CODE: 21237 | | 10g. CITIZEN OF WHAT COUNTRY?: USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th Grade; College (1-4 or 5 +): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): FRED BATTLE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): PAULINE JENKINS | | | |
| 19a. INFORMANT'S NAME (Type/Print): PAULINE M. BATTLE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7210 JIMROW COURT/BALTIMORE, MD 21237 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY | | 20c. LOCATION — City or Town, State: CATONSVILLE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner | | 22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVE. | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARRHYTHMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto.MD.

31. DATE FILED (Month, Day, Year): NOV 3 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 2696

PER MR CURZIE, DR PERETTI IS RELEASING
THIS BODY AS NON-MED

89 29697

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY LOUISEBRAXTON | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 29, 1989 | 3. TIME OF DEATH: 9:32A M |
| 4. SOCIAL SECURITY NUMBER: 217-40-7556 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/16/43 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 208 N. Spring Ct. | 21234 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12): 12th | College (1-4 or 5+): | Nurses Aid | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Steve Penn | Carrie Braxton |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Alexander Braxton | 5214 Hillwell Rd. Baltimore, MD 21229 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore Cemetery | Baltimore, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Gladys Warner | WM. C. MARCH F/H 1101 E. NORTH AVE. |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | DIABETES MELLITUS | 5yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | PANCREATIC INSUFFICIENCY | 6yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | ALCOHOL ABUSE | 10 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COCAINE ABUSE
NEPHROTIC SYNDROME

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Charles A. Bergman Jr MD | D32816 | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHARLES A. BERGMAN JR.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached; use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29698

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mildred Barnes | | | | 2. DATE OF DEATH (Month / Day / Year): 11 / 1 / 89 | 3. TIME OF DEATH: 12 — P M |
| 4. SOCIAL SECURITY NUMBER: 214 22 9197 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7/25/26 | 8. BIRTHPLACE (State or Foreign Country): Md |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hosp of Baltimore | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Balto. City |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: Md | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4663 Delaware Ave | | 10f. ZIP CODE: | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Benjamin Barnes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Virgie Pinkney | | | |
| 19a. INFORMANT'S NAME (Type/Print): William E. Gaines, Jr | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2112 McCulloh St Balto, Md 21217 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cem | | 20c. LOCATION — City or Town, State: Catonsville, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | 22. NAME AND ADDRESS OF FACILITY: March F.H. West 4300 Wabash Ave | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Hepatic Encephalopathy | 2 mos |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Alcoholic Cirrhosis | several years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] Weinberg MD - Resident Physician | 9312 | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Irving Weinberg MPH D., Dept of Medicine, Sinai Hospital, Baltimore.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | [signature] Julia Davidson-Randall |

OHMH-18 Rev 1/89

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89 29699

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Ethel (Elbethel) | H. | Brown | 11-1-89 | M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 219 20 9330 | 1 ☐ M 2 ☒ F | 78 YRS. | | | 9/2/1911 | Ga. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 501 Dolphin St. | Balto. | None |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | none | Baltimore | XX 1 ☐ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 501 Dolphin St. | 21217 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | | Cook--Seamstress | DrugFair |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Lemon Payne | Lula Payne |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Leroy Payne | 1208 Westerlee Place Apt. 20 21228 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore National | Balto., Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | James A. Morton & Sons 1701 Laurens Street Balto., Md. 21217 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complicetions that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, shock, or heert feilure. List only one cause on eech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Myocardial infarction | Some days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

DM, HTN, obesity

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| James Evans MD | D 20040 | ▶ 11/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
700 Washington Blvd, Balto, Md 21230

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29700

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|
| NELLIE W. BURT | | 10 / 27 / 89 | 7:20 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214073587 | 1 ☐ M 2 ☒ F | 92 YRS. | | | May 20 1897 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| SACRED HEART HOSPITAL | Cumberland | ALLEGANY COUNTY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | Allegany | Lonaconing | 1 ☐ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 33 Furnace St. | 21539 | U. S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | No | 1 ☐ YES 2 ☒ NO Specify: | White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Celanease Fibers | Laborer |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Burt | Janet Allerdice |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| James Burt | Cumberland Md. 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) | Frostburg Mem. Park | Frostburg Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Frederick W Warnick | Boal-Warnick Funeral Home Lonaconing Md. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Atherosclerotic coronary artery disease | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Thomas Devlin | D21458 | ▶ 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THOMAS DEVLIN, M.D. 55 JACKSON STREET LONACONING, MD. 21539

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached & the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Florence R Blum
2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89
3. TIME OF DEATH: 6 58 A M
4. SOCIAL SECURITY NUMBER: 065-26-0928
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/24/27
8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring
9c. COUNTY OF DEATH: Montgomery

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Silver Spring
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 11104 Foxglove lane
10f. ZIP CODE: 20901
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home maker
16b. KIND OF BUSINESS/INDUSTRY: Home

17. FATHER'S NAME (First, Middle, Last): Herman Chibnik
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadelle Spieler

19a. INFORMANT'S NAME (Type/Print): Joel L. Blum
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same address as #10

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other): King David Memorial Gardens
20c. LOCATION — City or Town, State: Falls Church, Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes, Falls Church, Va. 22046

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Sarcoid

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): F. Gravins, MD, 10313 Georgia Ave, Silver Spring, MD
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89 29702

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from page 4 as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Viola ELIZABETH Baker | | | 2. DATE OF DEATH Month / Day / Year: 10-29-89 | 3. TIME OF DEATH: 8:23PM M |
| 4. SOCIAL SECURITY NUMBER: 212-01-6962 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/7/1907 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 8 W. Saratoga Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: n/a |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: n/a | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 8 Charles Plaza, North Tower Apt. 1901 | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Exec. Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Board of Directors for Commercial Credit | |
| 17. FATHER'S NAME (First, Middle, Last): John Louis Lavezza | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa L. Bacigalupa Lavezza | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Theresa L. Verville | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4111 Sixth Street, Baltimore, Maryland 21225 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kevin E. Ecker | 22. NAME AND ADDRESS OF FACILITY: McCully Funeral HOme of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO HEAD ONLY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: XXX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 10-30-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. 111 Penn Street,Baltimore,MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Erika Davidson-Randell | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MRS. GENEVA CARTWRIGHT | | | | 2. DATE OF DEATH (Month, Day, Year): 10 30 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-26-1121 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7 13 13 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 2000 NORTHBOURNE ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2000 Northbourne Rd. | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Edmund Lamb | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cherry | | |
| 19a. INFORMANT'S NAME (Type/Print): Pearlene Alston | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2000 Northbourne Rd. Balto., MD 21239 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin R. Williams | 22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVENUE 21202 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. END STAGE RENAL DISEASE | 10 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPER KALEMIA
HYPOTENSION
MALNUTRITION

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S. Chintrisna, MD | 29c. LICENSE NUMBER: D17673 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. CHINTRISNA, MD. MARYLAND GENERAL HOSP., BALT., MD. 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

ONMN-18 Rev 1/89

89 29704

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PHYLLIS BEATRICE CUSH | | 2. DATE OF DEATH (Month, Day, Year): 10--25--1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-98-1576 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 01-20-1926 |
| 8. BIRTHPLACE (State or Foreign Country): GUYANA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 14565 DORSEY MILL ROAD | 9b. CITY, TOWN OR LOCATION OF DEATH: GLENWOOD | 9c. COUNTY OF DEATH: HOWARD | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: GLENWOOD | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 14565 DORSEY MILL ROAD | 10f. ZIP CODE: 21738 | 10g. CITIZEN OF WHAT COUNTRY?: GUYANA | |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): n/a |
| | | 16b. KIND OF BUSINESS/INDUSTRY: n/a |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): JOHN LUCIUS CUSH | 18. MOTHER'S NAME (First, Middle, Maiden Surname): PRINCESS ALBERTHA KEWLEY |
| 19a. INFORMANT'S NAME (Type/Print): RUDOLPH W. CUSH | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14565 DORSEY MILL RD.,GLENWOOD,MD 21738 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Linthicum Chapel Cem. | 20c. LOCATION — City or Town, State: Clarksville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535 | 22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL HOME ELLICOTT CITY,MARYLAND 21043 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Bronchogenic carcinoma - stage IV — 9 months

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD, Anorexia / cachexia, Anemia.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jon K. Munford MD | 29c. LICENSE NUMBER: D 30573 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-26-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2 Knell North Columbia MD 21045 | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

Notes on

89 29705

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WAN YIM CHEUNG (Wan Cheung) | | | | | 2. DATE OF DEATH MONTH 11 DAY 2 YEAR 89 | | 3. TIME OF DEATH 11:52 A M |
| 4. SOCIAL SECURITY NUMBER 212 48 3777 | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 62 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) OCT. 20, 1927 | | 8. BIRTHPLACE (State or Foreign Country) CHINA |
| 9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH -- | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE MARYLAND | 10b. COUNTY BALTIMORE | 10c. CITY, TOWN OR LOCATION CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER 6430 CLIFTON FORGE CIRCLE | | 10f. ZIP CODE 21228 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: ASIAN |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 6 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER | 16b. KIND OF BUSINESS/INDUSTRY RESTAURANT | |
| 17. FATHER'S NAME (First, Middle, Last) HO BING CHEUNG | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) FONG YU NG | |
| 19a. INFORMANT'S NAME (Type/Print) YUN KUEN CHEUNG | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6430 CLIFTON FORGE CIRCLE, CATONSVILLE, MARYLAND 21228 | |
| 20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LORRAINE PARK CEMETERY | 20c. LOCATION — City or Town, State WOODLAWN, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Witzke | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Melanoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER Lawrence Kass MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Univ of Md Hosp. Lawrence Kass MD | | |
| 31. DATE FILED (Month, Day, Year) NOV 3 1989 | 32. REGISTRAR'S SIGNATURE Erika Davidson-Randell | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29706

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RUTH S. CARRICK | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 31, 1989 | 3. TIME OF DEATH: 7:30 P.M. |
| 4. SOCIAL SECURITY NUMBER: 433-38-2397 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): OCT. 29, 1906 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 404 CHALFONTE DRIVE | | 9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 404 CHALFONTE DRIVE | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER | 16b. KIND OF BUSINESS/INDUSTRY: BALTIMORE CITY |
| 17. FATHER'S NAME (First, Middle, Last): ERIC SCHROETER | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY MAYER | |
| 19a. INFORMANT'S NAME (Type/Print): CLINTON CARRICK | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 CHALFONTE DRIVE, CATONSVILLE, MD. 21228 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK CEMETERY | 20c. LOCATION — City or Town, State: WOODLAWN, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | several years. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Arteriosclerosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Old age | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY — M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D18429 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-01-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALLAN PEREZ M.D. 1009 FREDERICK ROAD, BALTIMORE, MARYLAND 21228

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2706

89 29707

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William A. Christian
2. DATE OF DEATH (Month, Day, Year): 11 1 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212 26 9256
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/4/30
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): 2045 Ruxton Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2045 Ruxton Avenue
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5 +): 4 plus
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nuclear Med. Tech
16b. KIND OF BUSINESS/INDUSTRY: Federal Govt.
17. FATHER'S NAME (First, Middle, Last): Abner Christian
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth M. Pankey
19a. INFORMANT'S NAME (Type/Print): Mrs. Arlene D. Watson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2045 Ruxton Avenue Balto., Md. 21216
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest
20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James A. Morton
22. NAME AND ADDRESS OF FACILITY: James A. Morton & Sons, 1701 Laurens Street Balto., Md 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for [illegible] as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Prostate Carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD
29c. LICENSE NUMBER: D2447 6
29d. DATE SIGNED (Month, Day, Year): 11/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NISHA A. SOREY 2300 Garrison Blvd Balto Md 21216
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Lisha Davidson-Kendall

DNMN-18 Rev 1/89

Forest Service

89 29708

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine Mary Cawley (Catherine Cawley)
2. DATE OF DEATH (Month, Day, Year): 11-2-89
3. TIME OF DEATH: 2:25 A M
4. SOCIAL SECURITY NUMBER: 219-18-9398
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-6-15
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): MFL: Mason F. Lord Nursing Home Eastern Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Roosdale Harbor View
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7009 Fait Ave
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? USA.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Wht
15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housework
16b. KIND OF BUSINESS/INDUSTRY: At Home
17. FATHER'S NAME (First, Middle, Last): Thomas W. Clemson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gladys M. King
19a. INFORMANT'S NAME (Type/Print): Gladys White
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1520 Vesper Ave. Dundalk, Md. 21222
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery
20c. LOCATION — City or Town, State: Eastwood, Balto. Co., Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles D. Zeiler
22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave.

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gangreene left lower leg & foot
DUE TO (OR AS A CONSEQUENCE OF):
b. Sepsis
DUE TO (OR AS A CONSEQUENCE OF):
c. Sacral Pressure Sore.
DUE TO (OR AS A CONSEQUENCE OF):
d. S/P Cardiac Arrest

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
DAT - Incontient of B-B.
IDDM.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 11-2-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lynda PAC - MFL/Eastern Ave Balt, Md 21224.
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson/Kendall

OHMH-18 Rev 1/89

89 2708

89 29709

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEONARD RUSSELL CLARK | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 06:38am M |
| 4. SOCIAL SECURITY NUMBER: 213-03-0802 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8/29/04 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: LaVale | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1135 Braddock Rd | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): n/a; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Westvaco | 16b. KIND OF BUSINESS/INDUSTRY: Paper | |
| 17. FATHER'S NAME (First, Middle, Last): Arnold G. Clark | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Grove | | |
| 19a. INFORMANT'S NAME (Type/Print): Ruth Clark | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1135 Braddock Rd. LaVale, Md. 21502 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. View Cemetery | 20c. LOCATION — City or Town, State: Barton, Md. 21521 | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wayne Bank | 22. NAME AND ADDRESS OF FACILITY: Boal-Warnick F. Home Westernport, Md. 21562 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or raspiratory arreat, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Bilateral Severe Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Chronic Obstructive Pulmonary Disease and Emphysema

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe Insulin dependent diabetes mellitus
Dehydration, Bilateral Amputation
old MyoCardial Infarction - old age

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S C Sandhir MD | 29c. LICENSE NUMBER: D14464 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. SIKANDER SANDHIR 48 TARN TERRACE FROSTBURG, MD. 21532

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

4

89 29710

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bertha A. Chilcoat | | | 2. DATE OF DEATH (Month, Day, Year): 10--31-89 | 3. TIME OF DEATH: 1:10 AM |
| 4. SOCIAL SECURITY NUMBER: 215-24-7084 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-4-1902 | 8. BIRTHPLACE (State or Foreign Country): Balto. City |
| 9a. FACILITY NAME (If not institution, give street and number): 4607 Powell Avenue | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore,MD. | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4607 Powell Avenue | | 10f. ZIP CODE: 21206 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory | 16b. KIND OF BUSINESS/INDUSTRY: Bugle Laundry |
| 17. FATHER'S NAME (First, Middle, Last): Clyde Cunningham | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary | |
| 19a. INFORMANT'S NAME (Type/Print): Aunieta Fay Ashe | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4607 Powell Avenue -21206 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith CEmetery | 20c. LOCATION — City or Town, State: Baltimore,Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy | | 22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. | 6415 BElair Road Baltimore,Md.-21206 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. GASTRIC CARCINOMA | 3 Mos |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Francis X. Carmody | 29c. LICENSE NUMBER: D01373 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FRANCIS X. CARMODY 201 E. Univ. Pkwy. S208, Balto, MD 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall |

DHMH-18 Rev 1/89

89 29711

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified in ence.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ANNA ADLINE DERENBERGER
2. DATE OF DEATH (Month, Day, Year): Nov 1, 1989
3. TIME OF DEATH: 4:50 p. M
4. SOCIAL SECURITY NUMBER: 218-36-7122
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 93 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/10/1896
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 711 Brinkwood Road
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Joseph Bridickas
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marcella UNKNOWN
19a. INFORMANT'S NAME (Type/Print): Paul T. Briggs
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 213 S. Furrow St. Baltimore, Md. 21223
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Neal Glover
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | 5 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Gebhard T. Cole MD
29c. LICENSE NUMBER: 021512
29d. DATE SIGNED (Month, Day, Year) ▶ 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3455 Wilkens Ave. Balt, Md. 21229
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Files 89

89 29712

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BEATRICE G DISNEY | | | | | | | 2. DATE OF DEATH (Month, Day, Year): 10 30 89 | 3. TIME OF DEATH: 814 PM M |
| 4. SOCIAL SECURITY NUMBER: 217-12-6700 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | | 7. DATE OF BIRTH (Month, Day, Year): MARCH 6, 1913 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | | | 9c. COUNTY OF DEATH: A.A. COUNTY | |
| RESIDENCE OF DECEDENT | | | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | | 10c. CITY, TOWN OR LOCATION: PASADENA | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 689 DUVALL HIGHWAY | | | 10f. ZIP CODE: 21122 | | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 th grade; College (1-4 or 5+): none | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER | | | | 16b. KIND OF BUSINESS/INDUSTRY: DOMESTIC | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM COSTELLO | | | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH BACHING | |
| 19a. INFORMANT'S NAME (Type/Print): RAY P. DISNEY, SR. | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS 10 a-f | | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN MEMORIAL PARK | | | | 20c. LOCATION — City or Town, State: GLEN BURNIE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Shane Savage | | | 22. NAME AND ADDRESS OF FACILITY: McCULLY FUNERAL HOME 3204 MOUNTAIN RD PASADENA, MARYLAND | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION — Myocardial Infarction | 4 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): CHRONIC CONGESTIVE HEART FAILURE — Chronic Congestive heart failure | one wk |
| | c. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE — Coronary Artery Disease | years |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |
|---|---|

| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Constantine Padussis MD | D18823 | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CONSTANTINE J. PADUSSIS, M.D. 7310 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached & used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

sites 89

89 29713

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

2541

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANTHONY D. FABRIZIO | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 27 / 89 | 3. TIME OF DEATH: 2:05 A M |
| 4. SOCIAL SECURITY NUMBER: 579-09-3195 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3-24-1901 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): VAMC - Loch Raven | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: Baltimore City |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Woodlawn | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2051 Summit Ave. | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW 1 & WW 2 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer | 16b. KIND OF BUSINESS/INDUSTRY: US Government | |
| 17. FATHER'S NAME (First, Middle, Last): Francis Fabrizio | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary C. Pinto | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Myrtle N. Fabrizio | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2051 Summit Ave. Baltimore, MD 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem. | 20c. LOCATION — City or Town, State: Garrison, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John K [illegible] | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Palmonary Mycobacterium Avium Intracellulare | 4/89 |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Unstable Angina | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary Artery Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Seconary Pseudomonas Pneumonia | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Anemia
Chronic constipation
Malnutrition

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: David B. Aiello MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID B. AIELLO MD LOCH RAVEN VA HOSPITAL

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] |

DHMH-18 Rev 1/89

89 29714

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES GABE | | | | 2. DATE OF DEATH (Month, Day, Year): 11 2 89 | 3. TIME OF DEATH: 1605 M |
| 4. SOCIAL SECURITY NUMBER: 216-09-2956 | 5. SEX: 1 M 2 F | 6. AGE (In yrs. last birthday): 100 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1/31/1889 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Balto. Co. General Hosp. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ------ | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 716 N. Charles St. | | 10f. ZIP CODE: 21201 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW I | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Pipe Fitter & Plumber | 16b. KIND OF BUSINESS/INDUSTRY: Sparrows Point-Shipyard |
| 17. FATHER'S NAME (First, Middle, Last): Henry Gabe | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Lorine Haines | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2211 Southland Road Baltimore, MD 21207 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery | 20c. LOCATION — City or Town, State: Woodlawn, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen M. Jenkins | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | 0 min |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: JAUNDICE, CVA, DEMENTIA, CONTRACTURES, PVD

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C Ravi MD | 29c. LICENSE NUMBER: D37333 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11.2.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RAVI MD, BCGH, RANDALLSTOWN, MD 21133. | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Filed 89

89 29715

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use if the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROBERT LEROY GILLESPIE | | | 2. DATE OF DEATH (Month, Day, Year): 10 28 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 481-30-1410 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 08-06-1916 | 8. BIRTHPLACE (State or Foreign Country): ILLINOIS |
| 9a. FACILITY NAME (If not institution, give street and number): 5125 RONDEL PLACE | | 9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA | | 9c. COUNTY OF DEATH: HOWARD |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: COLUMBIA | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 5125 RONDEL PLACE | | 10f. ZIP CODE: 21044 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1942-1945 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): VETERINARIAN | | 16b. KIND OF BUSINESS/INDUSTRY: VETERINARY MEDICINE |
| 17. FATHER'S NAME (First, Middle, Last): SHERMAN GILLESPIE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): AGNES WILLIAMSON | | |
| 19a. INFORMANT'S NAME (Type/Print): KEVIN R. GILLESPIE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19023 CANADIAN CT., GAITHERSBURG, MD 20879 | | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CRESTLAWN MEM. GDN. | | 20c. LOCATION — City or Town, State: MARRIOTTSVILLE, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M005353 | | 22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL HOME, ELLICOTT CITY, MARYLAND 21043 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Alcoholism | YRS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ASCVD, Diabetes, Emphysema

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) HOME

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Melvin J Kordon MD | D06588 | ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MELVIN J KORDON MD 2000 CENTURY PLAZA COLUMBIA MD 21044

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 31989 | Erika Davidson-Randall |

DNMN-16 Rev 1/89

89 29716

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) AMOS IVAN GAMBER / Amos IVAN GAMBER | | | | | 2. DATE OF DEATH MONTH 10 DAY 31 YEAR 89 | | 3. TIME OF DEATH 735P M |
| 4. SOCIAL SECURITY NUMBER 214-01-0669 | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 87 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) JUNE 24, 1902 | | 8. BIRTHPLACE (State or Foreign Country) MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | | 9c. COUNTY OF DEATH -- | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MARYLAND | 10b. COUNTY BALTIMORE | | 10c. CITY, TOWN OR LOCATION CATONSVILLE | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER 8 MONMOUTH ROAD | | | 10f. ZIP CODE 21228 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MECHANIC | | | 16b. KIND OF BUSINESS/INDUSTRY AUTOMOTIVE | |
| 17. FATHER'S NAME (First, Middle, Last) RUBEN GAMBER | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY HARRIS | | |
| 19a. INFORMANT'S NAME (Type/Print) HELEN R. GAMBER | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 N. ROLLING ROAD, CATONSVILLE, MD. 21228 | | | | |
| 20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MT OLIVE CEMETERY | | | 20c. LOCATION — City or Town, State RANDALLSTOWN, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Lawrence Witzke | | | 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Septicemia | 10 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute Leukemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Ralph Alhalel M.D | D13170 | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RALPH ALHALEL / 900 Caton Ave Baltimore 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 10/31/NOV 3 1989 | Gloria Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29717

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas Green
2. DATE OF DEATH (Month, Day, Year): 11 02 89
3. TIME OF DEATH: 6 45 ☐A ☐M
4. SOCIAL SECURITY NUMBER: 225-60-1630
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 44 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 2 1 45
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Liberty Med. Center
9b. CITY, TOWN OR LOCATION OF DEATH: Balto.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5301 Maple Ave.
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. OECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): John Green
18. MOTHER'S NAME (First, Middle, Maiden Surname): Velma Thomas
19a. INFORMANT'S NAME (Type/Print): Sylvia Green
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5301 Maple Ave., Balto., Md. 21215
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cem.
20c. LOCATION — City or Town, State: Landsdowne, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: MARCH F.H WEST 4300 Wabash Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Intractable Cardiac Arrythemia. | 18 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Sepsis suspected. | 12 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | End Stage Renal disease. | Several years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year) —
28b. TIME OF INJURY — M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED —
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) —
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) —

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Nasir MD House Officer
29c. LICENSE NUMBER: D35711
29d. DATE SIGNED (Month, Day, Year) ▶ 11/02/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MOKHTAR NASIR Liberty Medical Center, Baltimore, MD
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kinard

OHMH-18 Rev 1/89

Files 88

89 29718

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ORA S. HARCUM | | | 2. DATE OF DEATH (Month / Day / Year): 11/1/89 | 3. TIME OF DEATH: 7:55 AM |
| 4. SOCIAL SECURITY NUMBER: 216-20-1684 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-1-1898 | 8. BIRTHPLACE (State or Foreign Country): U.S. |
| 9a. FACILITY NAME (If not institution, give street and number): 3922 Fairview Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. City | | 9c. COUNTY OF DEATH: N/A |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3922 Fairview Ave. | | 10f. ZIP CODE: 21216 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housekeeper | 16b. KIND OF BUSINESS/INDUSTRY: Domestic | |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | | |
| 19a. INFORMANT'S NAME (Type/Print): Percy Harcum | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3922 Fairview Ave. 21216 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Auburn Cemetery 11/4/89 | 20c. LOCATION — City or Town, State: Balto. Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Sophie B Seth | 22. NAME AND ADDRESS OF FACILITY: Seth's Funeral Service Office 4644 Pimlico Road Baltimore, MD. 21215 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiac Arrhythmia | Immed. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | ASCVD | YRS |
| DUE TO (OR AS A CONSEQUENCE OF): c. | Chronic Phlebitis Leg | YRS |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| E. J. Adkins M.D. | D14571 | ▶ 11/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

Howard, Sonya

1118 0 9 4 89 29719

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| SONYA | YVETTE | HOWARD | OCTOBER 31, 1989 | 04:15 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 212-78-3036 | 1 ☐ M 2 ☒ F | 29 YRS. | | | 8-15-60 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| THE JOHNS HOPKINS HOSPITAL | BALTIMORE CITY | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | BALTIMORE CITY | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 204 NORTH WOLFE STREET | 21231 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| 11th Grade | | UNEMPLOYED | NA |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| REGINAL HOWARD | HARRIET GUNDY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JOSEPH & HARRIET WHITTEN | 204 NORTH WOLFE STREET/BALTIMORE, MD 21231 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | CEDAR HILL CEMETERY | ANNE ARUNDEL CO. MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Gladys Warner | WM.C. MARCH F.H. 1101 E. NORTH AVE. |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary Hypertension | 3mo |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Right Ventricular Dilatation | 3mo |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | OUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

4 months post partum

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Linda Mundy | | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Linda Mundy Johns Hopkins Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29720

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... ding physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use ... the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month - Day - Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Mary Evelyn Herman | | 11 - 01 - 89 | 7:30P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-34-6957 | 1 ☐ M 2 ☒ F | 80 YRS. | | | 09 08 09 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Dulaney Towson Nursing Home | Towson | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | --------- | Baltimore | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 6101 Loch Raven Blvd. Apt. 204 | 21239 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Secretary | Church |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Harry Rowe | Bertha Moberly |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Donald A. Herman | 3A Maidstone Court Rosedale, Md. 21237 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Baltimore Cemetery | Balto. City, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Charles S. Zeiler | Charles S. Zeiler & Son Inc. 901 S. Conkling St. |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory failure | 4hrs |
| | DUE TO (OR AS A CONSEQUENCE OF): Emphysema | yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mark Kamas MD | D32453 | ▶ 11-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29721

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Sallie Harris (Sallie Harris)
2. DATE OF DEATH — MONTH: 10 DAY: 25 YEAR: 89
3. TIME OF DEATH: 1105 PM
4. SOCIAL SECURITY NUMBER: 216-68-8141
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/25/06
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2821 Brighton Street
10f. ZIP CODE: 21216
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Willie Williams
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Williams
19a. INFORMANT'S NAME (Type/Print): Lois Neely
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2821 Brighton St. Balto. Md. 21216
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt Calvary Cem.
20c. LOCATION — City or Town, State: Brooklyn, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Carl A Estep
22. NAME AND ADDRESS OF FACILITY: Estep Brothers Funeral Home, P.A. 1300 Eutaw Pl. Baltimore, Md. 21217

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Septic Shock. | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Decubitus Ulcer | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Diabetes Melitus | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: S/P Right Bkla Knee amputation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Ahmed Hossavi MD
29c. LICENSE NUMBER: D37353
29d. DATE SIGNED (Month, Day, Year): 10-25-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ahmed Hossavi MD Liberty Medical Center
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Jan Davidson-Randall

DHMH-16 Rev 1/89

1SJeS e8

89 29722

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Otis Leland HARRIS | | 2. DATE OF DEATH (Month, Day, Year): October 31, 1989 | 3. TIME OF DEATH: 11:52A M |
| 4. SOCIAL SECURITY NUMBER: 242 282753 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 15 1922 |
| 8. BIRTHPLACE (State or Foreign Country): North Carolina | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville 21237 | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Essex | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2005 Tred Avon Rd. | | 10f. ZIP CODE: 21221 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Foreman | 16b. KIND OF BUSINESS/INDUSTRY: Box Co. | |
| 17. FATHER'S NAME (First, Middle, Last): David Harris | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Geneva Wadford | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Harris, Wife | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2005 Tred Avon Rd. Balto., Md. 21221 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith | 20c. LOCATION — City or Town, State: Baltimore Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Balto., Md. 21221 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Severe End-Stage Chronic Obstructive Pulmonary Disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D38543 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. K. Scruggs 9000 Franklin Square Drive Baltimore, MD 21237 | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: [signature] | |

DHMH-18 Rev 1/89

89 29723

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MATTHEW NMI JOHNSON
2. DATE OF DEATH (Month, Day, Year): 11 01 89
3. TIME OF DEATH: 1622 EST PM
4. SOCIAL SECURITY NUMBER: 220 30 7444
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-31-1934
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): University Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Balto.
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1000 Mt. Holly St.
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY: State of Md.
17. FATHER'S NAME (First, Middle, Last): Hourice Johnson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie Hughes
19a. INFORMANT'S NAME (Type/Print): JANIE JOHNSON
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Mt. Holly St., Balto., Md. 21229
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet. Cem.
20c. LOCATION — City or Town, State: Owings Mills, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: March F/H West, 4300 Wabash Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | RESPIRATORY ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | PULMONARY METASTASES | 2 WK |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | SOFT TISSUE SARCOMA | 2 YR |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
POST OBSTRUCTIVE PNEUMONITIS
RIGHT PLEURAL EFFUSION

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: 038683
29d. DATE SIGNED (Month, Day, Year): ▶ 11-01-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CARL SHAMPTER, UNIV OF MD CANCER CTR 22 SOUTH GREENE ST BALTO 21201
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

ITEM #19a FILM #G659 PER: F.H. 01/08/90 J.A.

89 29724

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas Howard Jones

2. DATE OF DEATH: MO 11 DAY 2 YEAR 89

3. TIME OF DEATH: 1 15 PM

4. SOCIAL SECURITY NUMBER: 213-03-8853

5. SEX: 1 X M 2 ☐ F

6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS DAYS | IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 4/13/09

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Annapolis Hospital

9b. CITY, TOWN OR LOCATION OF DEATH

9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Anne Arundel

10c. CITY, TOWN OR LOCATION

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO

10e. STREET AND NUMBER: 2004 Fairy Farms Road

10f. ZIP CODE: 21401

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? X 1 YES 2 ☐ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown | College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): sales

16b. KIND OF BUSINESS/INDUSTRY: manufacturing

17. FATHER'S NAME (First, Middle, Last): Thomas Harvey Jones, Sr.

18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Gray

19a. INFORMANT'S: MRS J. DELANO HANZSCHE ~~Helen J. Hanzsche~~

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Osborne Avenue/Balto. MD 21228

20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wye Cemetery

20c. LOCATION — City or Town, State: Wye Oak, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter L. Ashton

22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Estate, PA 736 Edmondson Ave. Balto. MD 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BRAIN ANOXIA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CARDIO RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

c. Metastatic Liver Cancer of unknown primary — 4d

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Failure, Hypoalbuminemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew Gordon MD

29c. LICENSE NUMBER: D31997

29d. DATE SIGNED (Month, Day, Year): ▶ 11/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Andrew GORDON MD 16 Murray Ave ANNAPOLIS Md 21401

31. DATE FILED (Month, Day, Year): NOV 3 1989

32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 should be used as the burial-transit permit, Pages 1, 2, 3 should
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2215

89 29725

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BOOKER T. JOHNSON / Booker Johnson | | | 2. DATE OF DEATH (Month, Day, Year): October 28, 1989 | 3. TIME OF DEATH: 04:15 p M |
| 4. SOCIAL SECURITY NUMBER: 239-60-6557 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/09/37 | 8. BIRTHPLACE (State or Foreign Country): N. CAROLINA |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 106 SUNMAR CT, BALTIMORE, MARYLAND | | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCK DRIVER | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES TYSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE JANES INGRAN | | |
| 19a. INFORMANT'S NAME (Type/Print): KATHERINE JOHNSON | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 SUNMAR CT, BALTIMORE, MARYLAND 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GALILEE CEMETERY, | | 20c. LOCATION — City or Town, State: WAKEBORO, N.C. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: ESTEP BROTHERS FUNERAL SERVICE, P.A. 1300 EUTAW PL, BALTIMORE, MD. 21217 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Intracerebral Homorrhage | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | | ▶ 10/28/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jamal Abdel-Halim, M.D. C/O Maryland General Hospital

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | [signature] Gladys Davidson-Randall |

DHMH-16 Rev 1/89

89 29726

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Curtis L. Koonce | | 2. DATE OF DEATH: MONTH 10 DAY 31 YEAR 89 | 3. TIME OF DEATH: 9:15 P M |
| 4. SOCIAL SECURITY NUMBER: 216-42-6304 | 5. SEX: 1 M 2 F | 8. AGE (In yrs. last birthday): 43 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1-19-46 |
| 6. BIRTHPLACE (State or Foreign Country): FLORIDA | | | |
| 9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER: 1200 ROSSITER AVENUE APT. 1A | | 10f. ZIP CODE: 21239 | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12thGrade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATNER'S NAME (First, Middle, Last): LEROY KOONCE | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN BEUFORD | | |
| 19a. INFORMANT'S NAME (Type/Print): FLANCINA KOONCE | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1200 ROOSITA AVE. APT. 1A/BALTO. MD 21239 | | |
| 20a. METHOD OF DISPOSITION: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALTIMORE CEMETERY | 20c. LOCATION — City or Town, State: BALTIMORE, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Willis | 22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVE. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or reapiratory arreat, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute myelogenous leukemia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. HIV + | 2 yrs. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Myelofibrosis | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Vasculitis

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO — to be performed

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)

27. MANNER OF DEATH: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Edward A. Johnson MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 10/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward A. Johnson 630 Melvin Dr. | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DNMH-16 Rev 1/89

89 2726

89 29727

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Blair | Kinsman | Nov. 2, 1989 | 6:45 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 385-01-4497 | 1 [X] M 2 [ ] F | 74 YRS. | | | 12-=21-1914 | Penna. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 2813 White House Rd. | Riva | Anne Arundel |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Anne Arundel | Riva | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2813 White House Rd. | 21140 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 4 | Oceanographer | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Lewis Kinsman | Elizabeth Balir Kinsman |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Dorothy Kinsman | 2813 White House Rd. Riva, Md. 21140 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Suburban Crematory | Silver Sprind Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | W. Brooks Bradley, Inc. 2134 Willowspring Rd. 21222 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Colon Cancer | 3 mo. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | BM0986844 | ▶ 11-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
David E. Matteson 107 Ridgely Ave. Annapolis Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | [signature] |

DHMH-18 Rev 1/89

89 29728

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in obtaining burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SAMUEL LASCUOLA | | | 2. DATE OF DEATH (Month, Day, Year): 11-2-89 | 3. TIME OF DEATH: 7 51 A M |
| 4. SOCIAL SECURITY NUMBER: 216-28-7448 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2-5-17 | 8. BIRTHPLACE (State or Foreign Country): Louisiana |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Sykesville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 5922 Snowdens Run Road | | 10f. ZIP CODE: 21784 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Italy; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): General Contractor | 16b. KIND OF BUSINESS/INDUSTRY: Construction | | |
| 17. FATHER'S NAME (First, Middle, Last): Giovan LaScuola | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa DiFatta | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Concetta LaScuola | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5922 Snowdens Run Road Sykesville, MD 21784 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Memorial Park | 20c. LOCATION — City or Town, State: Sykesville, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Stephen M. Jenkins | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PERITONITIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC CONGESTIVE HEART FAILURE
CARDIOMYOPATHY
CHRONIC RENAL FAILURE

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D19502 | 29d. DATE SIGNED (Month, Day, Year): 11-2-89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ORLANDO B. CONANAN MD, BRCH, RANDALLSTOWN MD. 21133 | | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Lisha Davidson-Randall | | |

OHMH-16 Rev 1/89

89 2728

89 29729

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NAOMI LIVERS | | | 2. DATE OF DEATH: MONTH OCT. DAY 26 YEAR 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215-22-2292 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): May 31 1902 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severn | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 8395 Pioneer Drive | | 10f. ZIP CODE: 21144 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): George Bowen | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Pipe |
| 19a. INFORMANT'S NAME (Type/Print): Clementine Carter | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8395 Pioneer Drive, Severn, MD 21144 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arputus Memorial Park | 20c. LOCATION — City or Town, State: Balto. Co. Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dwayne Lowry | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Pkwy., Balto., Md. 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASCVD — DUE TO (OR AS A CONSEQUENCE OF): | YRS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: BULLOUS PEMPHIGOID

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Tyson M.D. | 29c. LICENSE NUMBER: D 10208 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard F. Tyson, M.D. 936 W. North Avenue Balto. Md. 21217

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29730

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HENRY MORROW | | | 2. DATE OF DEATH (Month, Day, Year): 11 - 1 - 89 | 3. TIME OF DEATH: 8:10 A M |
| 4. SOCIAL SECURITY NUMBER: 223-05-383F | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 2-6-08 | 8. BIRTHPLACE (State or Foreign Country): N.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Levindale Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 10 W. 20th St. | | 10f. ZIP CODE: 21218 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumbers' Helper | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Mace Morrow | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Lillie Morrow | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 W. 20th St. Balto, MD 21218 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garden of Eternal Hope | 20c. LOCATION — City or Town, State: Westminister, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner | 22. NAME AND ADDRESS OF FACILITY: Wm. C. Marsh F/H 1101 E. North Avenue | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PROBABLE ASPIRATION PNEUMONIA | 1 DAY |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. INABILITY TO SWALLOW | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CEREBROVASCULAR ACCIDENT | YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: MULTIPLE INFECTED DECUBITUS ULCERS

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: STAFF MD | 29c. LICENSE NUMBER: D30951 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-1-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A.J. LUCCO MD 2434 W BELVEDERE AVE. BALTO 21215-7299 | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 29731

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN GEORGE MATHEOS | | 2. DATE OF DEATH: Month Nov. Day 1, Year 1989 | 3. TIME OF DEATH: 2:00 AM |
| 4. SOCIAL SECURITY NUMBER: 232-03-4759 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-14-02 |
| 8. BIRTHPLACE (State or Foreign Country): Greece | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 3127 Willoughby Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: - | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 816 Rappolla Street | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Restaurateur | 16b. KIND OF BUSINESS/INDUSTRY: Food | |
| 17. FATHER'S NAME (First, Middle, Last): George John Matheos | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene | | |
| 19a. INFORMANT'S NAME (Type/Print): George J. Matheos | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3886 Greenmeadow Lane, Davidsonville, Md. 21035 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greek Orthodox Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ann L. Matthews | 22. NAME AND ADDRESS OF FACILITY: Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Lung Cancer. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition 2° to Lung Cancer and poor apetite

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

28. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Panayiotis A Baltatzis MD | D28949 | ▶ 11-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PANAYIOTIS BALTATZIS, M.D., 6660 Belair Rd., Baltimore, MD. 21206

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Gloria Tuitson-Randall |

DHMN-16 Rev 1/89

89 2931

89 29732

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): emma R. McLELLAN | | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 219-16-3338 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): July 28 1899 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): HARFORD GARDEN NURSING CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE CITY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | BALTIMORE CITY | BALTIMORE | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 522 E. FORT AVENUE | 21230 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12): 8th grade | College (1-4 or 5 +): — | Homemaker | own Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Thomas Mortimer | Helen Folger |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Marion R Mc Lellan | 900 Waterview Dr Balto 21226 Md |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Loudon Park Mausoleum | Balto Md |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Stanley M Folsom | McCully Funeral Home 237 Polyson Ave Balto Md 21225 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CRF-ANEMIA

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D17042 | ▶ 31 october 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ARTHUR M. NELSON M.D 3640 Fords Lane Balto MD 21225

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Erika Davidson-Randall |

DHMH-16 Rev 1/89

89 2732

89 29733

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CYRIL H NICKEL | | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 7 PM M |
| 4. SOCIAL SECURITY NUMBER: 175 12 1599 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 02 09 15 | 8. BIRTHPLACE (State or Foreign Country): PITTSBURG |
| 9a. FACILITY NAME (If not institution, give street and number): HOWARD Co GENERAL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Columbia MD | 9c. COUNTY OF DEATH: HOWARD | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: ELLICOTT CITY | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 10118 CENTURY DRIVE | | 10f. ZIP CODE: 21043-0000 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARETAKER/SEXTON | 16b. KIND OF BUSINESS/INDUSTRY: CEMETERY |
| 17. FATNER'S NAME (First, Middle, Last): NICKEL | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): BAUER |
| 19a. INFORMANT'S NAME (Type/Print): RICHARD NICKEL | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10118 CENTURY DR., ELLICOTT CITY, MD 21043 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. MARYS CEMETERY | 20c. LOCATION — City or Town, State: Ross Township. PA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] 000525 | 22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL 15214 ELLICOTT CITY, MD. 21043 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel diseese or condition resulting in death) →
a. STROKE
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST
b. ATHEROSCLEROSIS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.
PNEUMONIA

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: MD 25210 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD. | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained [illegible] or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 29734

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDNA E. ORWIG | | | 2. DATE OF DEATH (Month, Day, Year): 11/2/89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 220-24-3618 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 6/2/13 | 8. BIRTHPLACE (State or Foreign Country): PA |
| 9a. FACILITY NAME (If not institution, give street and number): 7312 Heinle Ave. | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 7312 Heinle Ave. | | 10f. ZIP CODE: 21237 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+): / | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: |
| 17. FATHER'S NAME (First, Middle, Last): Charles Archer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary A. Diffendasfer | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Larson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 403 K. Cedar Run Place, Catonsville, MD. 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens Of Faith | | 20c. LOCATION — City or Town, State: Fullerton, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Elmer S Rowland | | 22. NAME AND ADDRESS OF FACILITY: Cvach/Rosedale Funeral Home, Inc. 1211 Chesaco Ave. Balto. MD. 21237 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HISTORY OF CORONARY ARTERY BY PASS GRAFT 1983

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J.M. Nichols MD

29c. LICENSE NUMBER: 029197

29d. DATE SIGNED (Month, Day, Year): 11/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. M. NICHOLS MD 9000 FRANKLIN SQUARE DR. BALTO, MD. 21237

31. DATE FILED (Month, Day, Year): NOV 3 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29735

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PHILIP J. PALMISANO, SR. | | | | 2. DATE OF DEATH: MONTH 11 DAY 2 YEAR 89 | 3. TIME OF DEATH: 10:30 A M |
| 4. SOCIAL SECURITY NUMBER: 219-01-5575 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-5-17 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 5813 Oakland Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Arbutus | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Arbutus | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 5813 Oakland Road | | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | 16b. KIND OF BUSINESS/INDUSTRY: Lumber Company | |
| 17. FATHER'S NAME (First, Middle, Last): William P1 Palmisano | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace E. Pinkler | |
| 19a. INFORMANT'S NAME (Type/Print): Shirley May Palmisano | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5813 Oakland Road Baltimore, MD 21227 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Elkridge, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christopher N. Miles | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Md. 21229 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory Failure | Immediate |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Metastatic laryngeal carcinoma | 6 mo |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Laryngeal Cancer | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURRED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William C Waterfield MD | 29c. LICENSE NUMBER: 024356 | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William Waterfield St. Agnes Hosp. Oncology Dept. 21229 | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DNMH-18 Rev 1/89

89 29736

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained for use as the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clyde L. Portee (Partee)
2. DATE OF DEATH (Month, Day, Year): 10-30=89
3. TIME OF DEATH: 11:15PM M
4. SOCIAL SECURITY NUMBER: 215-38-7502
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-3-1931
8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): 1102 Druid Hill
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1100 Druid Hill Avenue
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? U S A
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Clyde L. Portee
18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Rhodes
19a. INFORMANT'S NAME (Type/Print): Shirley Page
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3614 Mohawk Avenue Baltimore, Md 21207
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [XX] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory
20c. LOCATION — City or Town, State: Baltimore, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: March F/H West 4300 Wabash Avenue

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX YES 2 [ ] NO — PARTIAL
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [XX] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [XXX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle, Jr. MD
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 10-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., MD 111 Penn Street, Baltimore, MD 21201 vc

31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

ONMH-16 Rev 1/89

89 29737

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John R. Robertson
2. DATE OF DEATH (Month, Day, Year): 10 17 1989
3. TIME OF DEATH: 2:30a M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): XX75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 10 16 1914
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg, MD
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: XXX MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Lonaconing, MD
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 20 E. Hanekamp Street
10f. ZIP CODE: 21539
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S. Postal Service
16b. KIND OF BUSINESS/INDUSTRY: Mail Carrier
17. FATHER'S NAME (First, Middle, Last): Henry D. Robertson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jean Anderson Robertson
19a. INFORMANT'S NAME (Type/Print): Mary Robertson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20 E. Hanpkamp St. Lonaconing, Md. 21539
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. View Cemetery
20c. LOCATION — City or Town, State: Moscow Mills Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert W Warnick
22. NAME AND ADDRESS OF FACILITY: Boal-Warnick Funeral Service Westernport, Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Myocardial infarction | 1 hr |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Arteriosclerosis | 3 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Hypothyroid, Carcinoma colon

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: George Breza MD
29c. LICENSE NUMBER: D12532
29d. DATE SIGNED (Month, Day, Year): ▶ 10/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George Breza MD, 912 Seton, Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

6

DHMH-16 Rev 1/89

89 29738

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BERNARD SCHULTZ
2. DATE OF DEATH — MONTH 10 DAY 31 YEAR 89: 10-31-89
3. TIME OF DEATH: 3:22 PM
4. SOCIAL SECURITY NUMBER: 215099791
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05/02/10
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE COUNTY
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 928 S. BINNEY ST
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 7 YEARS — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRINTING
16b. KIND OF BUSINESS/INDUSTRY: SUP. ST. OF MD.
17. FATHER'S NAME (First, Middle, Last): JACOB SCHULTZ
18. MOTHER'S NAME (First, Middle, Maiden Surname): JOSEPHINE WIELINSKI
19a. INFORMANT'S NAME (Type/Print): MR. EDWARD SCHULTZ
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3716 HUDSON STREET BALTO. MD. 21224
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEMETERY
20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski
22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HEPATIC FAILURE HEPATIC FAILURE | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. ELECTROLYTE IMBALANCE | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
28. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: I. Ivarra, M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. IRENE IVARRA CHURCH HOSPITAL CORPORATION
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Lisha Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29739

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARTHA JANE STEIMLING | | 2. DATE OF DEATH (Month, Day, Year): 10-31-89 | 3. TIME OF DEATH: 9 30 AM M |
| 4. SOCIAL SECURITY NUMBER: 216-24-0888 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 59 59 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH: 1-26-30 |
| 8. BIRTHPLACE (State or Foreign Country): OHIO | | | |
| 9a. FACILITY NAME (If not institution, give street and number): HARBOR VEIW HOSPITAL Harbor Hospital Center | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MARYLAND Baltimore, Md. | 9c. COUNTY OF DEATH | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDAL | 10c. CITY, TOWN OR LOCATION: GLENBURNIE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1009 STANE ROAD | | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 YEARS; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): I.C. ISAACS | 16b. KIND OF BUSINESS/INDUSTRY: SUPERVISOR | |
| 17. FATHER'S NAME (First, Middle, Last): STEPHENSEN | 18. MOTHER'S NAME (First, Middle, Maiden Surname): | | |
| 19a. INFORMANT'S NAME (Type/Print): MRS. MARSHA TAYLOR | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1009 STANE RD. GLEN BURNIE MD. 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN CEMETERY | 20c. LOCATION — City or Town, State: glen burnie MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski | 22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. METASTATIC Lung Carcinoma.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Bilateral Pleural Effusions
DUE TO (OR AS A CONSEQUENCE OF):
c. Head and neck ca.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas Rinaldi md. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas Rinaldi MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29740

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALLACE FRANCIS SCHATZ
2. DATE OF DEATH (Month, Day, Year): 11 / 1 / 89
3. TIME OF DEATH: 11 05 pm M
4. SOCIAL SECURITY NUMBER: 218-09-5433
5. SEX: 1 ☐ M 2 ☐ F (XX)
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01-05-1921
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: n/a

**RESIDENCE OF DECEDENT**

10a. STATE: MARYLAND
10b. COUNTY: HOWARD
10c. CITY, TOWN OR LOCATION: ELLICOTT CITY
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5101 MONTGOMERY ROAD
10f. ZIP CODE: 21043
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced (XX)
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO (X) — IF YES, GIVE WAR OR DATES: WW II
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO (X) Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MECHANIC
16b. KIND OF BUSINESS/INDUSTRY: LAWNMOWER SERVICE
17. FATHER'S NAME (First, Middle, Last): GEORGE FRANK SCHATZ
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET PEARL LAPOLE
19a. INFORMANT'S NAME (Type/Print): HOPE A. SCHATZ
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5101 MONTGOMERY ROAD, ELLICOTT CITY, MD 21043
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEM.PK.
20c. LOCATION — City or Town, State: ELKRIDGE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00535
22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL HOME, ELLICOTT CITY, MARYLAND 21043

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Lung Ca Small cell Ca | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | CRF | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO (X)
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): ▶ 11/2/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Monta St. Agnes Hosp, Inc
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 2710

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 must be signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVERETT M. SUMNER | | | | 2. DATE OF DEATH (Month, Day, Year): 11 / 1 / 89 | 3. TIME OF DEATH: 4:40 AM M | |
| 4. SOCIAL SECURITY NUMBER: 216-16-4799 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-3-1900 | 8. BIRTHPLACE (State or Foreign Country): VA. | |
| 9a. FACILITY NAME (If not institution, give street and number): CMNH Calvert Manor N.H. | | | | 9b. CITY, TOWN OR LOCATION OF DEATH: RISING SUN | 9c. COUNTY OF DEATH: CECIL | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: xxxxxxxxxxxxxxxxxxxx, Street | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3027 Dublin Road | | 10f. ZIP CODE: 21154 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Boiler Fireman | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Cloyd SUMNER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Liza LEONARD | |
| 19a. INFORMANT'S NAME (Type/Print): STELLA McCracken | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3027 DUBLIN ROAD, STREET, MD. 21154 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Flower Gap Cemetery | 20c. LOCATION — City or Town, State: Cana, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John H. Tillett | | 22. NAME AND ADDRESS OF FACILITY: Harkins Funeral Home Inc. 600 Main St., Delta PA | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cerebrovascular accident | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. | A.S.C.V.D. | 1 yr. |
| DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Neil Taylor M | 29c. LICENSE NUMBER: D-11115 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Neil Taylor, M.D., Rising Sun, Maryland

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 2971

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Emma J. Sites | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 7:50 a M |
| 4. SOCIAL SECURITY NUMBER: 212-07-3630 D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 97 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-4-1892 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 3016 McElldery Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3016 McElldery Street | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): unknown College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife | 16b. KIND OF BUSINESS/INDUSTRY: own home | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Werneth | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Augusta ? | |
| 19a. INFORMANT'S NAME (Type/Print): George Eberling | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): c/o 3016 McElldery Street/Balto. MD 21224 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oaklawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter D. Moran | | 22. NAME AND ADDRESS OF FACILITY: John A. Moran, Inc. 3000 E. Baltimore St. Balto. MD 21224 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Generalized Arteriosclerotic CVD | 10 yrs. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Theodore Wernik do | 29c. LICENSE NUMBER: D07517 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-1-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Theo. T. WERNIK M.D. - 429 S Chester St 21231 | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: | |

DHMH-16 Rev 1/89

Sales 89

89 29743

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be [illegible] hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVELYN SCHOENHAAR | | 2. DATE OF DEATH (Month, Day, Year): November 1, 1989 | 3. TIME OF DEATH: 8:44 AM |
| 4. SOCIAL SECURITY NUMBER: 215 74 7479 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 18, 1908 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 14 W. Cold Sring Lane APt 403 | 10f. ZIP CODE: 21210 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Harvey Buchman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Bell | | |
| 19a. INFORMANT'S NAME (Type/Print): Leslie H. Shoenhaar | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14 W. Cold Spring Lane Apt 403 Balto. Md. 21210 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lynn Burgee Henss | 22. NAME AND ADDRESS OF FACILITY: Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Md 21211 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. pulmonary edema | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: coagulopathy w/o congestive heart failure chronic renal insufficiency

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Cather A. Fedako MD | 29c. LICENSE NUMBER: N/A | 29d. DATE SIGNED (Month, Day, Year): ▶ November 1, 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Catherine A. Fedako MD | UNION MEMORIAL HOSPITAL | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 29744

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for ... as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| MYRTIS | ANN | TAYLOR | 10 30 89 | M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 227-20-5831 | 1 ☐ M 2 ☒ F | 64 YRS. | | | 12 27 24 | Va. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Bon Secour Hosp. | Balto. | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | | Balto. | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 2408 Frederick Ave | 21223 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Euguene Williams | Maggie Thomas |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Wade | 15 N. Ellamont St., Balto., Md. 21216 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Druidridge Cem. | Baltimore, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | March F.H. West<br>4300 Wabash Ave. |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Brain metastases | 2 mos. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Colon carcinoma. | 3 years. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D 33624 | ▶ 11/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

Items:23 thru 28f per ME G-657
11-9-89 cm

89 29745

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donald Jerome Tyler | | | 2. DATE OF DEATH (Month, Day, Year): 10-30-89 | 3. TIME OF DEATH: 4:43AM M |
| 4. SOCIAL SECURITY NUMBER: 217-52-4444 | 5. SEX: X M 2 F | 6. AGE (In yrs. last birthday): 38 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 27, 1951 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER: 1215 Saint Agnus Lane Apt. L | | 10f. ZIP CODE: 21207 | | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |
| 11. MARITAL STATUS: 1 Never Married 2 XX Married 3 Widowed 4 Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondery (0-12): | College (1-4 or 5+): 2 years Coll. | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Store Manager | | 16b. KIND OF BUSINESS/INDUSTRY: Federated Auto Parts |
| 17. FATHER'S NAME (First, Middle, Last): William H. Tyler | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Jackson | | |
| 19a. INFORMANT'S NAME (Type/Print): William J. Tyler | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Walden Birch Court Baltimore, Maryland 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery | 20c. LOCATION — City or Town, State: Balto, County, Maryland | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Rollins | 22. NAME AND ADDRESS OF FACILITY: Nutter Funeral Homes, Inc. 2501 Gwynns Falls Baltimore, Maryland 21216 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications thet ceused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) → a. Cranio-cerebral Injury with Complications

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

| | | | |
|---|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 NO | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 NO | 26. PLACE OF OEATH (Check only one) HOSPITAL: XXX Patient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 Natural 2 X Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10-23-89 | 28b. TIME OF INJURY: 12:03p M | 28c. INJURY AT WORK? 1 YES 2 X NO |
| 28d. DESCRIBE HOW INJURY OCCURED: Driver of Auto/Truck collision | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): on street | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Edmondson Ave & Cooks lane BaltimoreCity, Maryland | |

29a. CERTIFIER (Check only one)
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-30-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,M.D. | 111 Penn Street,Baltimore,MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 2745

89 29746

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and retained as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEONID TANKEL | | | 2. DATE OF DEATH (Month, Day, Year): 11 2 89 | 3. TIME OF DEATH: 9:30 a M |
| 4. SOCIAL SECURITY NUMBER: 114-30-4909 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months/Days; If under 24 hrs.: Hours/Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8-12-06 | 8. BIRTHPLACE (State or Foreign Country): Russia |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: New York | 10b. COUNTY: West Chester | 10c. CITY, TOWN OR LOCATION: East Chester | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 39 Forbes Boulevard | | 10f. ZIP CODE: 10709 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade; College (1-4 or 5+): 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Philatelist | 16b. KIND OF BUSINESS/INDUSTRY: Self-employed |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Tankel | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Raisa Gailis | |
| 19a. INFORMANT'S NAME (Type/Print): Luvov Berman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Sharpe Road Annapolis, MD 21401 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sharon Gardens | 20c. LOCATION — City or Town, State: Valhalla, NY |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, Md. 21229 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest. DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Renal failure DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: M.D | 29c. LICENSE NUMBER: D21686 | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/2/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Chaconas PLAVNER | 1509 Ritchie Highway Arnold, Maryland | | |
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE | | |

DHMH-16 Rev 1/89

89 2946

89 29747

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH C. TERRY
2. DATE OF DEATH: MONTH 11 DAY 1 YEAR 89
3. TIME OF DEATH: 5:45 A M
4. SOCIAL SECURITY NUMBER: 212-24-9393
5. SEX: 1 ☐ 2 ☒ F
6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 04-19-22
8. BIRTHPLACE (State or Foreign Country): Md
8a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
8b. CITY, TOWN OR LOCATION OF DEATH: Balto. City
8c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1620 N. Fulton Ave.
10f. ZIP CODE: 21217
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): James Coates
18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Chase

19a. INFORMANT'S NAME (Type/Print): Evangeline Stewart
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Chadnor Ct Balto. Md 21207

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet
20c. LOCATION — City or Town, State: Owings Mills, Md

21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: March F.A. West 4300 Wabash Ave

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Multiple Melo MA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. RESPIRATORY FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charlene D Ehmail MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶ 11/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used to obtain the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29748

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HOWARD J. THELEN — Howard John Thelen | | | | 2. DATE OF DEATH (Month, Day, Year): 11/1/89 | 3. TIME OF DEATH: 10:15 PM |
| 4. SOCIAL SECURITY NUMBER: 212-16-5296 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12/25/21 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: City |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: MD. | 10b. COUNTY: ---------- | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 622 ~~XXXX~~ SAVAGE ST. | | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. 2 | | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 8+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Warehouseman | | 16b. KIND OF BUSINESS/INDUSTRY: Crown Cork and Seal | |
| 17. FATHER'S NAME (First, Middle, Last): George Thelen | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Weitzel | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret M. Thelen | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 622 S. Savage St. Balto., Md. 21224 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus | | 20c. LOCATION — City or Town, State: Dundalk, Balto. Co., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles S. Zeiler | | 22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MYOCARDIAL INFARCTION | |
| DUE TO (OR AS A CONSEQUENCE OF): | a. MYOCARDIAL INFARCTION | DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | b. ATHEROSCLEROSIS | YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | b. ATHEROSCLEROSIS | |
| | c. | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEART FAILURE.

HEART FAILURE.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| A. F. Nazemi M.D. | CHURCH H | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. A. F. NAZEMI, M.D. CHURCH HOSPITAL

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Julie Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29749

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Thomas (ROBERT THOMAS)
2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89
3. TIME OF DEATH: 1150 A M
4. SOCIAL SECURITY NUMBER: 218-20-4198
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/30/24
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY
9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Somerset
10c. CITY, TOWN OR LOCATION: Crisfield, MD
10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 55 Somers Cove Apts.
10f. ZIP CODE: 21817
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: W. W. II Army
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 4; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman
16b. KIND OF BUSINESS/INDUSTRY: Seafood
17. FATHER'S NAME (First, Middle, Last): Harvey Thomas
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eleanora Denson
19a. INFORMANT'S NAME (Type/Print): Shirley R. Thomas
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 55 Somers Cove Apts. - Crisfield, MD 21817
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul's Cemetery
20c. LOCATION — City or Town, State: Marion Station, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert H. Bradshaw Jr.
22. NAME AND ADDRESS OF FACILITY: Bradshaw & Sons Funeral Home, 306 W. Main St. - Crisfield, MD 21817

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heert feilure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory insufficiency
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Lung Cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard E. Hughes
29c. LICENSE NUMBER: D08562
29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard E. Hughes 9 Medical Center Salisbury, MD 21801
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-1S Rev 1/89

#land #7
Item #8 per FH 11/6/89 sp

89 29750

1 - FOR STATE

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| Steven ~~STEPHEN~~ D. VILLERS | | | 2. DATE OF DEATH (Month, Day, Year): 10 30 89 | 3. TIME OF DEATH: 0900 A M |
| 4. SOCIAL SECURITY NUMBER: 480646278 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 40 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 7-21-49 | 8. BIRTHPLACE (State or Foreign Country): Iowa |
| 9a. FACILITY NAME (If not institution, give street and number): HOWARD County GENERAL Hosp | 9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA | 9c. COUNTY OF DEATH: HOWARD | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: COLUMBIA | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 5418 ELLIOTS OAK Rd, #1 | 10f. ZIP CODE: 21044 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYED CONSULTANT | 16b. KIND OF BUSINESS/INDUSTRY: COMPUTERS |
| 17. FATHER'S NAME (First, Middle, Last): HARRY C. VILLERS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DELORES MURPHY | |
| 19a. INFORMANT'S NAME (Type/Print): ELIZABETH B. VILLERS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5418 #1 ELIOTS OAK RD.,COLUMBIA,MD 21044 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAKLAND CEMETERY | 20c. LOCATION — City or Town, State: IOWA CITY,IOWA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Dallas Slack M00535 | | 22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL HOME ELLICOTT CITY,MARYLAND 21043 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ventricular fibrillation | 2 hr. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. cardiopulmonary arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Systemic lupus erythematosus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hemolytic anemia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Gertler | 29c. LICENSE NUMBER: D22448 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/30/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Gertler 11065 Little Patuxent Pkwy Col. Md 21045 | | |
| 31. DATE FILED (Month, Day, Year): 10/30/89 NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary F. VIA
2. DATE OF DEATH — MONTH: 11 DAY: 1 YEAR: 89
3. TIME OF DEATH: 1030 AM
4. SOCIAL SECURITY NUMBER: 217-34-4807
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/26/33
8. BIRTHPLACE (State or Foreign Country): S.C.
9a. FACILITY NAME (If not institution, give street and number): UMMS
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10a. STREET AND NUMBER: 2103 Hollins St
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Unknown — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): General Services
16b. KIND OF BUSINESS/INDUSTRY: Full-Time
17. FATHER'S NAME (First, Middle, Last): Will Carmichael
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Carver
19a. INFORMANT'S NAME (Type/Print): Mary Abrams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6428 Craigmont Rd. / Balto. MD 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cem.
20c. LOCATION — City or Town, State: Woodlawn, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams
22. NAME AND ADDRESS OF FACILITY: Wm. C. March Funeral Home 1101 E. North Avenue 21202

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain Death
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dept of Surgery UMMS 22 So Greene Balto MD
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29752

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| STANLEY | VIRTS | October 26, 1989 | 9:30 P.M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 236-01-8047 | 1 ☒ M 2 ☐ F | 87 YRS. | | | 9/23/1902 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | Garrett | Rt 1 Box 188 Swanton Md. | 1 ☐ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Rt 1 Box 188 Swanton Md. | 21561 | U. S. A |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO | White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5 +) | | |
| 12 | | Coal Operator | Coal |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William Virts | Mary Herman |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Wanda Taylor | Swanton Md. 21561 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Garrett Memorial Gardens | Oakland Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Frederick W Warnick | Boal-Warnick Funeral Service Westernport Md |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive heart failure | 2 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Wilbur Lamm MD (LAMM) | D25406 | ▶ 10-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Terry Williams, Memorial Hospital Medical Building, Cumberland, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 3 1989 | Lisha Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donald WILLIAM WHITE | | | | | 2. DATE OF DEATH (Month, Day, Year): 10 30 89 | 3. TIME OF DEATH: 2:45 PM |
| 4. SOCIAL SECURITY NUMBER: 217-34-6028 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 52 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10/15/37 | 8. BIRTHPLACE (State or Foreign Country): 52 |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2051 N. Division St. | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Albert White | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lousie Taliafero | |
| 19a. INFORMANT'S NAME (Type/Print): Theresa White | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1337 N. Fulton Avenue Baltimore, MD 21217 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ceda Hill Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin L. Williams | | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH FUNERAL HOME 1101 E. North Avenue | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heert failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO Inspection | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 vl

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 3 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Mrs. Mary J. Henry Whitehead
2. DATE OF DEATH — MONTH: 10 DAY: 30 YEAR: 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 229-34-5571
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-8-14
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): UNION MEMORIAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1520 EAST 33rd. STREET
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES X
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): WAXTER CENTER
16b. KIND OF BUSINESS/INDUSTRY: SENIOR CITIZEN CENTER
17. FATHER'S NAME (First, Middle, Last): MAURICE WALKER
18. MOTHER'S NAME (First, Middle, Maiden Surname): ARMINTA WILLIAMS
19a. INFORMANT'S NAME (Type/Print): ROSEMARY&JOHN HENRY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1520 EAST 33rd STREET/BALTIMORE, MD 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. OLIVER AME CH. CEMETERY
20c. LOCATION — City or Town, State: VORTON, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warren
22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVENUE 21202

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Cardiovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Diabetic Mellitus
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
dementia
depression
degenerative joint disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Carl Sperling MD
29c. LICENSE NUMBER: D28987
29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CARL SPERLING 5601 LOCH RAVEN BLVD 21239
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-18 Rev 1/89

89 29755

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LARRY WILLIS
2. DATE OF DEATH (Month, Day, Year): 10 28 89
3. TIME OF DEATH: 6:00 PM
4. SOCIAL SECURITY NUMBER: 217-68-0489
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 31 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-24-58
8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): Joseph Richey Hospice
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1700 NORTH SPRING STREET
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNKNOWN
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): DONNIE WILLIS SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): JESSIE RAY
19a. INFORMANT'S NAME (Type/Print): JESSIE WILLIS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1700 NORTH SPRING ST./BALTIMORE, MD. 21213
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESTERN STAR CEMETERY
20c. LOCATION — City or Town, State: CATONSVILLE, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner
22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVE.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Toxoplasmic Pneumonia + Encephalitis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. AIDS

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: D00759
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3074 Pond Place Randallstown 21133

31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-1S Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be taken with the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2752

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Catherine Barbara Wursthorn | | | | | 2. DATE OF DEATH MONTH DAY YEAR: 11/2/89 | | 3. TIME OF DEATH M: |
| 4. SOCIAL SECURITY NUMBER: 218-14-1326 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9-19-24 | | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 6 Greenwood Road | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Pikesville | | | 9c. COUNTY OF DEATH: Baltimore | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | | 10c. CITY, TOWN OR LOCATION: Pikesville | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 6 Greenwood Road | | | 10f. ZIP CODE: 21208 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): John S. Zorn | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Irene Frances McElwee | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Carl R. Wursthorn | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Greenwood Road Pikesville, MD 21208 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Vet. Cemetery | | | 20c. LOCATION — City or Town, State: Owings Mills, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen M Zonk | | | 22. NAME AND ADDRESS OF FACILITY: Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Massive Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Severe Hypertensive cerebrovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertensive cerebrovascular disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Samuel P. Scalia, MD

29c. LICENSE NUMBER: D10006

29d. DATE SIGNED (Month, Day, Year): ▶ 11-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SAMUEL P. SCALIA M.D. 7 CHURCH LANE 21208

31. DATE FILED (Month, Day, Year): NOV 3 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 2752

89 29757

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JANET MARIE WHISENANT | | 2. DATE OF DEATH (Month, Day, Year): October 30, 1989 | 3. TIME OF DEATH: 8:07 P M |
| 4. SOCIAL SECURITY NUMBER: 212-32-5426 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 54 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 8-23-35 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 2945 Hudson Street | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: - | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: - | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2945 Hudson Street | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: - | |
| 17. FATHER'S NAME (First, Middle, Last): Harry Lee Boyce | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Marie Dellinger | | |
| 19a. INFORMANT'S NAME (Type/Print): Raymond G. Whisenant | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2945 Hudson Street, Baltimore, Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State: Baltimore, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ann L. Matthews | 22. NAME AND ADDRESS OF FACILITY: Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio pulmonary Arrest — DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Renal Cell Carcinoma — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition, Pathologic Fracture Right Humerus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D36746 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Steven Benner MD. Johns Hopkins Oncology Center 600 N. Wolfe St. Baltimore Md.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Pendell |

DHMH-16 Rev 1/89

89 29758

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jeannette F. Williams
2. DATE OF DEATH (Month, Day, Year): Nov. 1, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 218 18 4040
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 5, 1917
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Francis Scott Key Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore City
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1055 Armistead Way
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House Wife
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Frederick
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Mousedale
19a. INFORMANT'S NAME (Type/Print): Lorraine Jones
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1718 Middlebrough Road Baltimore, Md. 21221
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery
20c. LOCATION — City or Town, State: Baltimore County, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Bruzdzinski Funeral Home PA 1407 Old Eastern Ave. Baltimore, Md. 21221

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF): b. Ventricular tachycardia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D10613
29d. DATE SIGNED (Month, Day, Year): ▶ 11-2-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. PERELMERA 406 Eastern Blvd. Balto Md 21221
31. DATE FILED (Month, Day, Year): NOV 3 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29759

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# WILLIAM E. YOUNGER SR. CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM E. YOUNGER SR. | | | 2. DATE OF DEATH (Month, Day, Year): 11/02/89 | 3. TIME OF DEATH: 1145 A M |
| 4. SOCIAL SECURITY NUMBER: 212-09-2436 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): NOV. 15, 1911 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: -- |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: CATONSVILLE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 903 RAMBLING DRIVE | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRESIDENT | 16b. KIND OF BUSINESS/INDUSTRY: C.M. ATHEY PAINT CO. |
| 17. FATHER'S NAME (First, Middle, Last): JAMES F. YOUNGER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CLARA RIDDLE | |
| 19a. INFORMANT'S NAME (Type/Print): WILLIAM E. YOUNGER JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 64 FAR CORNERS LOOP, SPARKS, MARYLAND 21152 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LORRAINE PARK MAUSOLEUM | 20c. LOCATION — City or Town, State: WOODLAWN, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell Witzke | | 22. NAME AND ADDRESS OF FACILITY: LEORY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular arrhythmias | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Renal Insufficiency | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Previous Cerebrovascular Accident. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pulmonary Edema
Hypothyroidism

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 X NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HAGOP M. TABAKIAN, M.D.; 900 CATON AVE., BALTO, MD 21229

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 3 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be obtained from the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 2252

89 29760

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| George | Allen | 11-3-89 | 10:29AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-09-2065 | 1 # M 2 ☐ F | 69 YRS. | | | 2/21/20 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1029 N. Carrollton Avenue | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | | Baltimore | 1 # YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1029 N. Carrollton Ave. | 21217 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: | 14. RACE — American Indian, Black, White, etc. Specify: |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 # Widowed 4 ☐ Divorced | 1 ☐ YES 2 # NO | 1 ☐ YES 2 ☐ NO | Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Allen | Edna Jones |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Ellamay Briscoe | 3643 Gelston Dr. Baltimore, Md. 21229 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 # Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mt. Auburn Cemetery | Westport, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Carl A. Estep | Estep Brothers Funeral Home [illegible]<br>1300 Eutaw Pl. Baltimore, Md. 21217 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hypertensive arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES XX NO | 1 ☐ YES XX NO |
| INSPECTION | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: XX 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| XX 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 11-4-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
|---|---|---|
| Ann M. Dixon, M.D. | 111 Penn Street, Baltimore, MD 21201 | VC |

| 31. DATE FILED (Month, Day, Year) | LOCAL REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | [signature] |

DHMH-16 Rev 1/89

89 29761

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BIRKENHEAD, MARY C. — Mary C. Birkenhead | 2. DATE OF DEATH (Month / Day / Year): 11 / 1 / 89 | 3. TIME OF DEATH: 2:45 PM |
| 4. SOCIAL SECURITY NUMBER: 577-07-2713 D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 99 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-17-90 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): MERIDIAN NURSING CENTER — HAMMONDS LANE | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Anne Arundel | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Pikesville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3114 Marnat Road | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Merrick | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Slining | | |
| 19a. INFORMANT'S NAME (Type/Print): Dorothy Lebo | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3114 Marnat Road Baltimore, Maryland 21208 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leone Znamierowski | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Left lower lobe Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Chronic Brain syndrome, | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| See MD | D17743 | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SEENIVASAN, MD, 606 Hammonds Lane, BALTO, Md, 21225

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julie Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| DOLORES | M. | BOWLING | Nov. 2, 1989 | 4:25 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 215-05-5201 | 1 ☐ M 2 ☒ F | 70 YRS. | | | Oct.31,1919 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 1807 Putty Hill Ave. | Parkville | Baltimore |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Parkville | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1807 Putty Hill Ave. | 21234 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 Years | ---------- | Cook | Retirement Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| George L. Reif | Mary Burger |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Leonard J. Bowling | 1807 Putty Hill Ave. Baltimore, MD 21234 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Gardens Of Faith Cemetery | Baltimore Co., MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | William E. Jonson Funeral Home, P.A. 8521 Loch Raven Blvd. Towson, MD 21204 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. COPD (chronic obstructive pulmonary disease) DUE TO (OR AS A CONSEQUENCE OF): | years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | Maryland D32939 | ▶ 11/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gregory S Poky WCA MD / 8406 Harford Rd / Balto, Md 21234

| 31. DATE FILED (Month, Day, Year) | REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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Items:28a thru 28f per ME G-658
12-12-89 cm

89 29763

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| Alphonsus R. Braun (AKA Alphonsus Jack Braun) | 11-3-89 | 7:00PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-42-3240 | 1 [X] M 2 [ ] F | 47 YRS. | | | 10-21-42 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany County |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Catonsville Manor | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1206 Gregory Avenue | 21207 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 9th grade | | Concrete Mason | Self-employed |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Melvin Braun | Doris Pletzer |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Shirley A. Braun | 1206 Gregory Avenue Baltimore, MD 21207 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Meadowridge Memorial Park | Elkridge, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Louis F. Smith | Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Shotgun wound of head | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX YES 2 [ ] NO | XX [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient XX DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 11-3-89 | 3:45pM | 1 [ ] YES 2 [X] NO | Subject shot |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Bushes | Old Cumberland-Elbinsvill Rd. MD-Pa line Allegany Co., Md. |

29e. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 11-4-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Ann M. Dixon,MD 111 Penn Street,Baltimore,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ( [illegible] (Jacquline V. Blue)
   Jacqueline V BLUE
2. DATE OF DEATH (Month, Day, Year): November 1, 1989
3. TIME OF DEATH: 12:54p
4. SOCIAL SECURITY NUMBER: 213-64-5307
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 36 YRS.
   IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12 16 52
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Rosedale
9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 8835 Fontana Lane
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): 3 Years
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Purchaser
16b. KIND OF BUSINESS/INDUSTRY: Parks Sausage
17. FATHER'S NAME (First, Middle, Last): Lewis Telly
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Blue
19a. INFORMANT'S NAME (Type/Print): Mildred Sutton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6432 Creigmont Avenue Baltimore, Md 21207
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King Memorial Park
20c. LOCATION — City or Town, State: Randallstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Harris
22. NAME AND ADDRESS OF FACILITY: 1701 McCulloh St Chatman-Harris F/H Baltimore, Md 21217

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adult Respiratory Distress Syndrome. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal failure.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: ▶ J Presser MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey Presser, M.D. 9000 Franklin Square Dr., Balto., 21237
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson Rondeau

DHMH-1e Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VANESSA BROWN
2. DATE OF DEATH (Month, Day, Year): 11 - 2 - 89
3. TIME OF DEATH: 10:07 M
4. SOCIAL SECURITY NUMBER: 218-60-4271
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/24/53
8. BIRTHPLACE (State or Foreign Country): MD

9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH:
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4732 Old Court Road
10f. ZIP CODE: 21208
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 5+
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): School Teacher
16b. KIND OF BUSINESS/INDUSTRY: Education

17. FATHER'S NAME (First, Middle, Last): Hezekiah Brown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Mae Miller

19a. INFORMANT'S NAME (Type/Print): Bernethia Anderson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4751 Belle'Forte Road Balto. Co., MD 21208

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens
20c. LOCATION — City or Town, State: Balto. Co., MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Maggalean D. Henson
22. NAME AND ADDRESS OF FACILITY: Maggalean Gilmore Funeral Service c/o Chatman-Harris Funeral Home 1701 McCulloh Street

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hemorrhagic tumor pericarditis
DUE TO (OR AS A CONSEQUENCE OF):
b. Undifferentiated Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
c. Pulmonary thromboembolism
DUE TO (OR AS A CONSEQUENCE OF):
d. Pulmonary Congestion + edema

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? ☑ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☑ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Yu-Wen Chang MD Associate Pathologist
29c. LICENSE NUMBER: D15646
29d. DATE SIGNED (Month, Day, Year): ▶ 11/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Yu-Wen Chang MD BCGH

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph

DHMH-18 Rev 1/89

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Item 6 11-7-89 Film G657 W.H.

89 29766

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH BYRD | | | | 2. DATE OF DEATH (Month, Day, Year): 11 3 89 | 3. TIME OF DEATH: 2 1/2 M |
| 4. SOCIAL SECURITY NUMBER: 226-30-4037 | 5. SEX: 1 ☐ M 2 ☐ F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 9 15 23 | 8. BIRTHPLACE (State or Foreign Country): VA |
| 9a. FACILITY NAME (If not institution, give street and number): LIBERTY MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE CITY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore MD | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2600 Liberty Road | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 11. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Labor | 16b. KIND OF BUSINESS/INDUSTRY: none | |
| 17. FATHER'S NAME (First, Middle, Last): Robert Byrd | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Lee Lundgren | |
| 19a. INFORMANT'S NAME (Type/Print): Bernice Cunningham | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3313 Sipple St Baltimore MD 21216 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Zion | 11 8 89 | 20c. LOCATION — City or Town, State: Baltimore MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Matthias L. Wiseman | | 22. NAME AND ADDRESS OF FACILITY: 2302 W North Ave 21216 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Metastatic Renal carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sher A Hashmi MD | 29c. LICENSE NUMBER: D24648 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-3-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHER HASHMI 2600 LIBERTY HEIGHTS AVE BALTIMORE 21215

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EDWARD C. BEETEM II | | | | 2. DATE OF DEATH (Month, Day, Year): 11/2/89 | 3. TIME OF DEATH: 7:55 A M |
| 4. SOCIAL SECURITY NUMBER: 174-05-2967 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-11-14 | 8. BIRTHPLACE (State or Foreign Country): Penna |
| 9a. FACILITY NAME (If not institution, give street and number): Manor Care - Ruxton | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Ruxton | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Timonium | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| 10e. STREET AND NUMBER: 705 W. Timonium Rd. | | 10f. ZIP CODE: 21093 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manufacture Rep. | 16b. KIND OF BUSINESS/INDUSTRY: Furniture | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Gilbert Beetem | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): May Grogan | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Doris Beetem | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 W. Timonium Rd. Balto. Md. 21093 | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ASHLAND Cemetery | 20c. LOCATION — City or Town, State: Carlisle, Penna. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John A Slade | | 22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins Funeral Home 4905 York Rd. Balto. Md. 21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Bronchopneumonia | 1 Month |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Cerebral Hemorrhage | 11 months |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: L Myrton Gaines M.D. | 29c. LICENSE NUMBER: D03656 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L. Myrton Gaines M.D. 6565 N. Charles St. Baltimore, Md. | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Georgia L. Brown | | 2. DATE OF DEATH (Month, Day, Year): October 22, 1989 | 3. TIME OF DEATH: 10:00 P M |
| 4. SOCIAL SECURITY NUMBER: 235-96-2734 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 30, 1908 |
| 8. BIRTHPLACE (State or Foreign Country): West Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: Baltimore | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: West River | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5216 Chalk Point Road | 10f. ZIP CODE: 20778 | 10g. CITIZEN OF WHAT COUNTRY? United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): John Harvey Snyder | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rachael Anderson | | |
| 19a. INFORMANT'S NAME (Type/Print): (Daughter) Margaret Louise Miller | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5216 Chalk Point Road, West River, Maryland 20778 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Middle Way Masonic Cemetery | 20c. LOCATION — City or Town, State: MIDDLE WAY ~~Martinsburg~~, West Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00690 ▶ Howard A Causon | 22. NAME AND ADDRESS OF FACILITY: Brown Funeral Home 327 West King Street, Martinsburg, W VA | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PNEUMONIA — 4 days

DUE TO (OR AS A CONSEQUENCE OF):
b. SEPTICEMIA — 4 days

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. CYSTITIS. — 4 days

DUE TO (OR AS A CONSEQUENCE OF):
d. CONGESTIVE HEART FAILURE.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Harjit Singh Attending Physician M.D. | 29c. LICENSE NUMBER: D 14160 | 29d. DATE SIGNED (Month, Day, Year): ▶ November 3, 1989 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harjit Singh, M.D. 5507-E Ritchie Highway, Baltimore, Maryland 21225 | | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson | | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GLADYS P BRONSTEIN
2. DATE OF DEATH — MONTH: 11 DAY: 02 YEAR: 89
3. TIME OF DEATH: 1235 PM
4. SOCIAL SECURITY NUMBER: 577-18-4519
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07 21 14
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: TAKOMA PARK MD.
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Hyattsville
10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 8105 17th Place
10f. ZIP CODE: 20783
10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married X 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 years — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Louis Park
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sadie G. Schmidt

19a. INFORMANT'S NAME (Type/Print): Richard D. Bronstein
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6566 N. Military Trail #567, West Palm Beach, Fla. 33407

20a. METHOD OF DISPOSITION: XX 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein
22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME, 232 CARROLL STREET, N.W., WASHINGTON, D.C.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Intracerebral hemorrhage | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Closed Head Injury | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

I

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 10/29/89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) — 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D21691
29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.H. DEE M.D. 8830 Cameron Smith III. S.S. No 205
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT LeRoy Bragg
2. DATE OF DEATH (Month, Day, Year): NOVEMBER 1, 1989
3. TIME OF DEATH: 6:48 PM
4. SOCIAL SECURITY NUMBER: 215-10-0294
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2/15/18
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 257 South Ellwood Avenue
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): cost acct.
16b. KIND OF BUSINESS/INDUSTRY: Revere Brass & Copper
17. FATHER'S NAME (First, Middle, Last): Robert L. Bragg
18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Musch
19a. INFORMANT'S NAME (Type/Print): Mary R. Glad
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 257 S. Ellwood Ave. Balto. MD 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parkwood Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Peter D. Baker
22. NAME AND ADDRESS OF FACILITY: John A. Moran, Inc. 3000 E. Baltimore St. Balto. MD 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Myocardial infarction | 1 week |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Cardiogenic shock | 1 day |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Diabetes mellitus | 5 years |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Earl Hope MD — EARL HOPE M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 11/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Johns Hopkins Hospital Baltimore MD 21287
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE:

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2770

89 29771

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran... 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELEANOR BERNSTEIN — Eleanor Bernstein
2. DATE OF DEATH (Month, Day, Year): 10 31 89
3. TIME OF DEATH: 1028 A M
4. SOCIAL SECURITY NUMBER: 065073746
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-10-15
8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): Howard Cty General
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia MD
9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Columbia MD
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6336 Cedar Lane APT. 247
10f. ZIP CODE: 21044
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MEDICAL ASSISTANT
16b. KIND OF BUSINESS/INDUSTRY: PHYSICIAN'S OFFICE
17. FATHER'S NAME (First, Middle, Last): SOLOMON HOFFMAN
18. MOTHER'S NAME (First, Middle, Maiden Surname): JENNY DAVIS
19a. INFORMANT'S NAME (Type/Print): MRS. SUZANNE B. SALSBURY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6120 LLANFAIR DRIVE COLUMBIA, MD 21044
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park
20c. LOCATION — City or Town, State: Balto, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Atherosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jerri Gershon MD
29c. LICENSE NUMBER: D26669
29d. DATE SIGNED (Month, Day, Year): ▶ 10-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Howard County General Hospital Emergency Room
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

89 2211

89 29772

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BUCZKOWSKI, GEORGE GEORGE BUCZKOWSKI | | | 2. DATE OF DEATH MONTH 11 DAY 04 YEAR 89 | 3. TIME OF DEATH M |
| 4. SOCIAL SECURITY NUMBER 215-03-0676 | 5. SEX 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday) 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4-23-11 |
| 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | |
| 9a. FACILITY NAME (If not institution, give street and number) 1252 CEDAR TREE LANE | 9b. CITY, TOWN OR LOCATION OF DEATH ANNAPOLIS MD. | 9c. COUNTY OF DEATH | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION BALTIMORE 623 S. BRADFORD STREET | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 623 S. BRADFORD STREET | | 10f. ZIP CODE 21224 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 YEARS; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LONGSHOREMAN | 16b. KIND OF BUSINESS/INDUSTRY WATER FRONT | |
| 17. FATHER'S NAME (First, Middle, Last) EDWARD BUCZKOWSKI | 18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY | | |
| 19a. INFORMANT'S NAME (Type/Print) MR. RICHARD BUCZKOWSKI | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1252 CEDAR TREE LANE ANNAPOLIS MD. 21401 | | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) SACRED HEART OF JESUS CEMETERY | 20c. LOCATION — City or Town, State BALTO. CO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Raymond L. Kaczorowski | 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. 21224 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of the biliary tract | Months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER COLGAN, R. | 29c. LICENSE NUMBER D3788 | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/2/K | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print) 703 Gilding Ave. Glen Burnie MD. 21061 | | | |
| 31. DATE FILED (Month, Day, Year) NOV 6 1989 | 32. REGISTRAR'S SIGNATURE | | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed ... by the funeral director, page 5 should be detached for use as the burial-transit permit. Please ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29773

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lilyan F.Brozik / Lilyan F. Brozik | | | 2. DATE OF DEATH Month: 11 Day: 4 Year: 89 | 3. TIME OF DEATH: 5:35 a M | | |
| 4. SOCIAL SECURITY NUMBER: 218078607 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-22-17 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md. | | | 9c. COUNTY OF DEATH: Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Baltimore | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 5228 Sixth Street | 21225 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 0 | Self-Employed | Tavern |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John Cervenka | Agnes Melichor |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Gloria Brozik Barnstorf | 5228 Sixth St. Balto. Md. 21225 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Cedar Hill Cemetery | Brooklyn Park, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Raymond A Weber (Reg.) George A. Weber & Sons Inc. | George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. metastatic breast cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| J.H. Jaster | — | ▶ 11-4-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.H. Jaster — Harbor Hospital Center — Baltimore Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | |

DHMH-18 Rev 1/89

89 29774

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Leo E. Barrett~~ Leo E. Barrett
2. DATE OF DEATH (Month, Day, Year): ~~11~~ 2 ~~89~~
3. TIME OF DEATH: 6:26 M
4. SOCIAL SECURITY NUMBER: 105-03-8613
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): ~~XXX~~ 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 09-05-15
8. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): St. Joseph Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Towson
9c. COUNTY OF DEATH: Balto.

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 823 Wellington Rd.
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs. — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Factory Worker
16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel

17. FATHER'S NAME (First, Middle, Last): Leo H. Barrett
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Margaret Meiers

19a. INFORMANT'S NAME (Type/Print): Mrs. Marie Benecke
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Parliament Ct. Baltimore, Md. 21212

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Bonaventure Cemetery
20c. LOCATION — City or Town, State: 14706 Allegany, New York

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert M. Kratz — ▶ Robert M. Kratz
22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF): Ischemic Heart Disease
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ~~Diseases~~ Illness.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
26d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: 13504
29d. DATE SIGNED (Month, Day, Year): 11/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E. Nichols M.D. 2300 Dulaney Valley Rd. Towson, Md. 21204

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DHMH-16 Rev 1/89

89 29775

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH V. CUNABAUGH
2. DATE OF DEATH (Month, Day, Year): 11-2-1989
3. TIME OF DEATH: 8:05 A.M.
4. SOCIAL SECURITY NUMBER: 215-09-5864
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 8-1-1916
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): 429 Yale Ave.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: /

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: /
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 429 Yale Ave. 21229
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): /
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.): Inspector
16b. KIND OF BUSINESS/INDUSTRY: Revere Copper & Brass
17. FATHER'S NAME (First, Middle, Last): Edward Cunabaugh
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Peacock
19a. INFORMANT'S NAME (Type/Print): Anna M. Cunabaugh
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 429 Yale Ave. 21229
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John J. Crown & Son Inc. — Joseph Howe
22. NAME AND ADDRESS OF FACILITY: John J. Crown & Son Inc. 901 Hollins St. 21223

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. End Stage Metastatic Melanoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pt w known brain metastatic disease from large malignant melanoma of shoulder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Stylon Hochuli
29c. LICENSE NUMBER: AS24385285449
29d. DATE SIGNED (Month, Day, Year): 11/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S Hochuli 900 Caton Ave Balt, Md. 21229

31. DATE FILED (Month, Day, Year): NOV 6 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29776

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): LENA R CELOZZI
2. DATE OF DEATH (Month, Day, Year): 11 05 89
3. TIME OF DEATH: 12 45 AM
4. SOCIAL SECURITY NUMBER: 212-03-3726
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 4/13/1914
8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): MERCY MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE 21224
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 326 N ROGNSON STREET
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER
16b. KIND OF BUSINESS/INDUSTRY: HOME

17. FATHER'S NAME (First, Middle, Last): DOMENICO BAZZARRI
18. MOTHER'S NAME (First, Middle, Maiden Surname): PASQUALINA TARCQUARONA
19a. INFORMANT'S NAME (Type/Print): MICHAEL D. CELOZZI SR.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5502 BELLE VISTA AVE BALTO. MD 21206

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SACRED HEART OF JESUS CEM.
20c. LOCATION — City or Town, State: BALTIMORE, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph N. Zannino Jr.
22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Jr. Funeral Home, 263 S. Conkling St. Balto. Md. 21224

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Chronic obstructive pulmonary disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Breast Ca.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D37777
29d. DATE SIGNED (Month, Day, Year): ▶ 11/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER CHALK 301 ST PAUL PL BALTIMORE

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Archives 89

89 29777

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emma E. Comes
2. DATE OF DEATH (Month, Day, Year): NOV 4th 89
3. TIME OF DEATH: 1 A M
4. SOCIAL SECURITY NUMBER: 213-10-8911
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 94 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-21-1895
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Pleasant View Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Mt. Airy
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Ellicott City
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3357-E N. Chatham Road
10f. ZIP CODE: 21043
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Candy Maker
16b. KIND OF BUSINESS/INDUSTRY: Candy Making
17. FATHER'S NAME (First, Middle, Last): John M. Walper
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katie Lang
19a. INFORMANT'S NAME (Type/Print): Madlyn Gourley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3358 Coventry Court Drive Ellicott City, MD 21043
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Neal Colaner
22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute cardiac event prob. myocardial infarction — HRS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Atherosclerotic coronary Artery disease

DUE TO (OR AS A CONSEQUENCE OF):

c. General Atherosclerosis

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: D alzheimers D Hypertension D trend

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Melvin Gordon MD
29c. LICENSE NUMBER: D06588
29d. DATE SIGNED (Month, Day, Year) ▶ 11/4/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Melvin Gordon MD 2000 Century Plaza Columbia MD 21044

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Jerold Bernstein/Randall

OHMH-18 Rev 1/89

Items:23 thru 28f per ME G-657
11-29-89 cm

89 29778

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| Eric | D. | Cottman | 10-30-89 | 10:32AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 169-48-4186 | 1 ☐ M 2 ☐ F | 30 YRS. | | | 2 19 59 | Pennsylvania |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Deaton Nursing | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Pennsylvania | | Chester | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1915 W. 4th Street | 19013 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Construction Worker | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Williams | Elizabeth Randolph |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Elizabeth Cottman | 341 W. 7th Street Chester, Pennsylvania 19013 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Greenmount Cemetary | Baltimore, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Berry Harris | 1701 McCulloh Street Chatman-Harris F/H Baltimore, Md 21217 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Head Injury with complications | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | | 9:55p M | 1 ☐ YES 2 ☒ NO | Subject found on steps |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Steps | 11th & Upland Streets Chester, Pennsylvania |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle, Jr. md | OCME | ▶ 10-31-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | |
|---|---|
| Mario F. Golle, Jr., MD | 111 Penn Street, Baltimore, MD 21201 vc |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29779

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ISAIAH N. CLAIBORNE SR.
2. DATE OF DEATH (Month, Day, Year): 11- 04- 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216-03-1483
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 08-16-12
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): home - 1717 Bethel Street
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: none

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: none
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1717 N. Bethel Street
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negroid
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade | College (1-4 or 5+): none
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Elevator Operator
16b. KIND OF BUSINESS/INDUSTRY: Business
17. FATHER'S NAME (First, Middle, Last): James Claiborne
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fannie Griffin
19a. INFORMANT'S NAME (Type/Print): Mattie Pemberton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1717 N. Bethel St. Baltimore, Md. 21213
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore, Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs Sr.
22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | METASTATIC RENAL CELL CARCINOMA | 8 WEEKS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NONE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): NA
28b. TIME OF INJURY: NA M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: NA
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): NA

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David M. Charlson MD
29c. LICENSE NUMBER: D37943
29d. DATE SIGNED (Month, Day, Year): ▶ 11/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST., BALTIMORE 21205
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29780

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH F. CONWELL
2. DATE OF DEATH: MONTH 10 DAY 31 YEAR 89
3. TIME OF DEATH: 11:45 PM
4. SOCIAL SECURITY NUMBER: 271-22-5389
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-26-06
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): KESWICK
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: CITY

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Balttmore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 700 W. 40th St.
10f. ZIP CODE: 21211
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Account Clerk
16b. KIND OF BUSINESS/INDUSTRY: Md. State Goverment
17. FATHER'S NAME (First, Middle, Last): Charles Fackner
18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Morgan
19a. INFORMANT'S NAME (Type/Print): Harvey J.Siegel
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 812 Blaustein Bldg. Baltimore, md. 21201
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery
20c. LOCATION — City or Town, State: Balto..Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John A Slade
22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins & Sons Co. 4905 york Rd.,Balto., Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Occlusive coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: M. Isabelle MacGregor MD
29c. LICENSE NUMBER: D13657
29d. DATE SIGNED (Month, Day, Year): ▶ 11.1.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. ISABELLE MACGREGOR KESWICK, 700 W 40TH ST BALTO. MD 21211
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-16 Rev 1/89

89 29781

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CARL BERGER CHRISTENSEN | | | 2. DATE OF DEATH (Month, Day, Year): Nov 1 1989 | 3. TIME OF DEATH: 2:00 p M |
| 4. SOCIAL SECURITY NUMBER: 350-10-6686 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1-23-1906 | 8. BIRTHPLACE (State or Foreign Country): Illinois |
| 9a. FACILITY NAME (If not institution, give street and number): Perry Point Veterans Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: ----- | | 9c. COUNTY OF DEATH: Cecil County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Parkville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 2616 Wendover Rd. | | 10f. ZIP CODE: 21234 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer | 16b. KIND OF BUSINESS/INDUSTRY: Printing Company |
| 17. FATHER'S NAME (First, Middle, Last): Sigurd Christensen | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Henrietta Fredrickson | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Carol B. Dankelman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2616 Wendover Rd. Balto., Md. 21234 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenmount Crematory | 20c. LOCATION — City or Town, State: Balto., Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hartley Miller | | 22. NAME AND ADDRESS OF FACILITY: Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic heart disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [XX] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [XX] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: [X] 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): XX [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: JOAQUIN R. GARCIA, M.D. Joaquin R. Garcia M.D. | | 29c. LICENSE NUMBER: D04271MD | 29d. DATE SIGNED (Month, Day, Year): 11/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joaquin R. Garcia M.D. | | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

OHMH-16 Rev 1/89

89 29782

Item 7 11-16-89 Film G657 W.H. Per F/H

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| James | Louis | Clark | 10-31-89 | 7:15PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 236-52-0343 | XX 1 M 2 F | 53 YRS. | | | 10/4/36 | Wilcoe, W Va |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 309 Bentwood Drive | Ft. Washington | Prince Georges Co. |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md | PG | Ft Washington | 1X YES 2 NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 309 Bentwood Drive | | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 Never Married XX 2 Married 3 Widowed 4 Divorced | 1XX YES 2 NO | 1 YES 2XX NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 Yrs | 6 Yrs | Dir of Services | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Jesse Clark | Helen Hough |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Rose Rollings Clark | Same as 10a,b,c,d,e,&f |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Lincoln Memorial | Suitland, Md |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| [signature] 180 | John TRhines Co 3015 12th St NE, DC 20017 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gunshot wounds to front of chest and abdomen and blunt trauma

DUE TO (OR AS A CONSEQUENCE OF): XXXXXXXXXXXXXXXXXX of the head

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX 1 YES 2 NO | XX 1 YES 2 NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: | OTHER: |
|---|---|---|
| 1XX YES 2 NO | 1 Inpatient 2 ER/Outpatient 3 DOA | 4 Nursing Home 5XX Residence 6 Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 Natural 2 Accident 3 Suicide 4XX Homicide 5 Pending Investigation 6 Could not be determined | 10-31-89 | 7:00PM | 1 YES 2XX NO | Subject shot and beaten |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| home | 309 Bentwood Drive, Ft. Washington, Prince Georges Co. MD |

29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 11-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)

Julia C. Goodin, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29783

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Items 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-removal permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edith B. CLEM | | | 2. DATE OF DEATH (Month, Day, Year): October 24, 1989 | 3. TIME OF DEATH: 6:40 P M |
| 4. SOCIAL SECURITY NUMBER: 234-70-1581 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): March 4, 1914 | 8. BIRTHPLACE (State or Foreign Country): Red Creek, WV |
| 9a. FACILITY NAME (If not institution, give street and number): Moran Manor Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Westernport | | 9c. COUNTY OF DEATH: Allegany |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Rawlings | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Route 3, Box 238 | | 10f. ZIP CODE: 21557 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Food Preparation | 16b. KIND OF BUSINESS/INDUSTRY: Health Care Facility | |
| 17. FATHER'S NAME (First, Middle, Last): George Harness Flanagan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary (Ketterman) Flanagan | |
| 19a. INFORMANT'S NAME (Type/Print): Marvin Clem | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2, Box 119, Keyser, WV 26726 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Waxler Cemetery | 20c. LOCATION — City or Town, State: Rawlings, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William B. Clem MOO 827 | | 22. NAME AND ADDRESS OF FACILITY: Rotruck Funeral Home 85 South Main Street, Keyser, WV 26726 | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Intractable Congestive Heart Failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Coronary Artery Disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: John H Tan | 29c. LICENSE NUMBER: D21244 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jesus H. Tan Frostburg Plaza Frostburg, Md. 21532

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29784

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): STANISLAUS T. JAMES CUDNIK (STANISLAUS CUDNIK.)
2. DATE OF DEATH (Month, Day, Year): 11 3 89
3. TIME OF DEATH: 7:15 PM
4. SOCIAL SECURITY NUMBER: 218-01-1215
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 2-8-16
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: CITY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 229 S. ROBINSON STREET
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 YEARS; College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUP.
16b. KIND OF BUSINESS/INDUSTRY: WESTERN ELECTRIC
17. FATHER'S NAME (First, Middle, Last): FRANK CUDNIK
18. MOTHER'S NAME (First, Middle, Maiden Surname): STANISLAWA MICHALAK
19a. INFORMANT'S NAME (Type/Print): MRS. MARIE CUDNIK
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 229 S. ROBINSON STREET BALTO. MD. 21224
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify): ENTOUBMENT
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEM
20c. LOCATION — City or Town, State: BALTO. MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski
22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME, 2525 FLEET STREET BALTO. MD. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Probable Aspiration Pneumonia.
DUE TO (OR AS A CONSEQUENCE OF):
b. Fx - (R) - Hip.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
c. ASHD CHF NI + Cardiac Arrest.
DUE TO (OR AS A CONSEQUENCE OF):
d. C Residual Mental Impairment.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael E. Smith M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11/3/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 100 E. PLEASANT ST. Balto. Md 21202.

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Dearden

DHMH-16 Rev 1/89

89 29785

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MORGAN, Clabon Morgan, Clabon T. Jr, | | | | 2. DATE OF DEATH: MONTH 11/ DAY 4 YEAR 89 | 3. TIME OF DEATH: 12 29 M |
| 4. SOCIAL SECURITY NUMBER: 215-22-0465 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 88 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-4-1901 | 8. BIRTHPLACE (State or Foreign Country): Balto. City |
| 9a. FACILITY NAME (If not institution, give street and number): MErcy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore,Md. | | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6040 Harford Road | | 10f. ZIP CODE: 21214 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Night Manager | 16b. KIND OF BUSINESS/INDUSTRY: Apts. | |
| 17. FATHER'S NAME (First, Middle, Last): Clabon T. Morgan Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence L. Kaiser | |
| 19a. INFORMANT'S NAME (Type/Print): Pamela E. Cady | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3713 Yolando Road Baltimore,Md.-21218 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore,MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathleen M. Murphy | | 22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. 6415 BElair Road Baltimore,MD.-21206 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. respiratory failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. adult respiratory distress syndrome | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. renal failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. aspiration pneumonia | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jeanette Friedman M.D. | 29c. LICENSE NUMBER: pending | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeanette Friedman Mercy Medical Center, Balto. MD 21202

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29786

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Margaret I. Crowther
2. DATE OF DEATH (Month, Day, Year): 11-2-89
3. TIME OF DEATH: 9:30 P. M
4. SOCIAL SECURITY NUMBER: 214-12-2537 B
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-3-05
8. BIRTHPLACE (State or Foreign Country): Balto. Md.
9a. FACILITY NAME (If not institution, give street and number): Manor Care-Rossville
9b. CITY, TOWN OR LOCATION OF DEATH: Rossville
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Rossville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6600 Ridge Road
10f. ZIP CODE: 21237
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): REdifer
18. MOTHER'S NAME (First, Middle, Maiden Surname): CAroline Fowler
19a. INFORMANT'S NAME (Type/Print): Anna C. Sevary
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4312 Raspe Avenue-21206
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery
20c. LOCATION — City or Town, State: Baltimore,Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: John C. Miller, Inc. — 6415 BElair Road Baltimore,Md.-21206

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Howard H Bull MD
29c. LICENSE NUMBER: D19793
29d. DATE SIGNED (Month, Day, Year): ▶ 11/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Howard H Bull MD 9618 Belair Rd Bultmore
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 2786

89 29787

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Evelyn A. Dise — Evelyn A. Dise | | | 2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89 | 3. TIME OF DEATH: 3pm M |
| 4. SOCIAL SECURITY NUMBER: 215075739 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-20-06 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Harbor Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: ====== |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5604 Park Road | | 10f. ZIP CODE: 21225 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Home Maker | |
| 17. FATHER'S NAME (First, Middle, Last): Asa Lowman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margarette Rhodes | | |
| 19a. INFORMANT'S NAME (Type/Print): Carolyn Buchheit | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5604 Park Avenue Baltimore, Maryland 21225 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C Davis | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. Anemia Renal Insufficiency

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypothyroidism, Congestive
DUE TO (OR AS A CONSEQUENCE OF):
d. Heart Failure

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): NA | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED: NA | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): NA | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Samuel E. Wilson M D | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-30-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samuel E. Wilson, Harbor Hospital | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 29788

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Theresa O. Durham
2. DATE OF DEATH — MONTH: 11 DAY: 03 YEAR: 89
3. TIME OF DEATH: 1049 A M
4. SOCIAL SECURITY NUMBER: 212200702
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 090620
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Columbia MD 21044
9c. COUNTY OF DEATH: Howard County

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: COLUMBIA
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10552 CROSS FOX LANE
10f. ZIP CODE: 21044
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 11th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): POST OFFICE
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): THOMAS MATTHEWS
18. MOTHER'S NAME (First, Middle, Maiden Surname): QUEENIE BROWN
19a. INFORMANT'S NAME (Type/Print): JANICE DURHAM SCOTT
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10552 CROSS FOX LANE/CLOUMBIA, MD 21044
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): KING MEMORIAL PK. CEM.
20c. LOCATION — City or Town, State: RANDALLSTOWN, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Julia R. Marsh
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F.H. 1101 E. NORTH AVENUE 21202

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardio-Vascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas F. Herbert MD Howard County Medical Examiner
29c. LICENSE NUMBER: D-5002
29d. DATE SIGNED (Month, Day, Year): 11-03-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas F. Herbert MD 3545 Ellicott Mills Dr. Ellicott City MD 21043
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29789

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHESTER J. DRIFT | | | 2. DATE OF DEATH (Month, Day, Year): November 2, 1989 | 3. TIME OF DEATH: 9:20 P. M. |
| 4. SOCIAL SECURITY NUMBER: 154-07-1122 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/29/1919 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY | | 9c. COUNTY OF DEATH: WICOMICO |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Delaware | 10b. COUNTY: Sussex | 10c. CITY, TOWN OR LOCATION: Lewes | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 324 Angola by the Bay | | 10f. ZIP CODE: 19958 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Printer | 16b. KIND OF BUSINESS/INDUSTRY: Legal Supplies | |
| 17. FATHER'S NAME (First, Middle, Last): Ignacz Drzewoszewski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva (Unknown) Drzewoszewski | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Drake | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1352 Isabella Court, Lakewood, New Jersey 08701 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern Shore Crematorium | 20c. LOCATION — City or Town, State: Georgetown, Delaware |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Melson Funeral Services, Ltd. Millsboro, Delaware 19966 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Squamous Cell Carcinoma of Lung | 3 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. E. Martin M.D. | 29c. LICENSE NUMBER: D30690 | 29d. DATE SIGNED (Month, Day, Year): 11/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James E. Martin, M.D. 145 E. Carroll St., Salisbury, MD. | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary H. Evans
2. DATE OF DEATH (Month, Day, Year): 11 2 89
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 213-32-0268
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3 25 31
8. BIRTHPLACE (State or Foreign Country): VA
9a. FACILITY NAME (If not Institution, give street and number): 2628 Beryl Avenue
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2628 Beryl Avenue
10f. ZIP CODE: 21205
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor
16b. KIND OF BUSINESS/INDUSTRY: Dept. of Employment Security
17. FATHER'S NAME (First, Middle, Last): Arthur Harris
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Fowlkes
19a. INFORMANT'S NAME (Type/Print): Saundra Eames Wright
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4411 Walton Farms Dr., Richmond, VA 23229
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore National Cem.
20c. LOCATION — City or Town, State: Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warren
22. NAME AND ADDRESS OF FACILITY: Wm. C. March F/H 1101 E. North Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ADVANCED CARCINOMA OF LUNG — 7 YRS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D11865
29d. DATE SIGNED (Month, Day, Year): ▶ 11/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.M. ZIMMERMAN MD 100 N. BROADWAY BALT. MD 21231
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 29791

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): James W. FLOOD | | | 2. DATE OF DEATH: MONTH 10 DAY 30 YEAR 89 | 3. TIME OF DEATH: 11:15 AM |
| 4. SOCIAL SECURITY NUMBER: 225-36-0928 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 1-12-25 | 8. BIRTHPLACE (State or Foreign Country): Va. |
| 9a. FACILITY NAME (If not institution, give street and number): Good Samaritan Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 1913 Hubert St. | | 10f. ZIP CODE: 21217 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 1945 - 1947 | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): X — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Operator | 16b. KIND OF BUSINESS/INDUSTRY: Steel Co. | |
| 17. FATHER'S NAME (First, Middle, Last): James Flood | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Cross | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Annie Flood | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1913 Hubert St. Balto. Md. 21217 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): G.F.V. Cemetery | 20c. LOCATION — City or Town, State: Owings Mills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph J. Callick | 22. NAME AND ADDRESS OF FACILITY: Baltimore, Md. 21213 — Callick F.H. 2431 E. Oliver St. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Chronic Obstructive Pulmonary Disease and Arteriosclerotic Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURRED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination, and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn Street, Baltimore, MD 21201 vl

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29792

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ... 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Kathleen Beatrice Franz | | | 2. DATE OF DEATH (Month, Day, Year): November 2, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 218 32 1004 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1906 | 8. BIRTHPLACE (State or Foreign Country): Ireland |
| 9a. FACILITY NAME (If not institution, give street and number): 704 Church Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Reisterstown | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 704 Church Road | | 10f. ZIP CODE: 21136 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Social Worker | 16b. KIND OF BUSINESS/INDUSTRY: Catholic Charities |
| 17. FATHER'S NAME (First, Middle, Last): Joseph Hughes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Farrell | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Kathleen M. Malinowski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 704 Church Road Reisterstown, Md. 21136 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Most Holy Redeemer Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis Wenrake | | 22. NAME AND ADDRESS OF FACILITY: MITCHELL-WIEDEFELD HOME, INC. 6500 York Road Baltimore, Md. 21212 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hepatic encephalopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic carcinoma of the colon | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD, Asthma

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Attending Physician | 29c. LICENSE NUMBER: D30631 | 29d. DATE SIGNED (Month, Day, Year): 11/3/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALAN REISINGER MD 5411 OLD FREDERICK RD | | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

OHMH-18 Rev 1/89

Series 89

89 29793

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Dorothy I. Giangrasso | | | 2. DATE OF DEATH (Month, Day, Year): 11- 4- 1989 | 3. TIME OF DEATH: 9:40 A.M |
| 4. SOCIAL SECURITY NUMBER: 220-03-3392 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-10-1913 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): 7517 Carson Avenue 21224 | | 9b. CITY, TOWN OR LOCATION OF DEATH: 21224 | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: 21224 | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7517 Carson Avenue | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4 or 5+): ----- | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Luther Matthews | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Flora | | |
| 19a. INFORMANT'S NAME (Type/Print): Mr. Domincik K. Giangrasso | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7517 Carson Avenue Baltimore, Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Joseph N. Zannino Jr. | | 22. NAME AND ADDRESS OF FACILITY: Joseph N. Zannino Jr. Funeral Home 263 S. Conkling Street Balto. Md. 21224 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cachexia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. depression | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Marie D. Chatham | D20907 | 11/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marie D. Chatham 12309 Cleghan Road Cockeysville, Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Gina Davidson-Randall |

DHMH-16 Rev 1/89

89 29794

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DAVID C. GRANDBERRY | | | | 2. DATE OF DEATH MONTH 11 DAY 3 YEAR 89 | 3. TIME OF DEATH 6:10 PM |
| 4. SOCIAL SECURITY NUMBER: 213-62-1087 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-18-19 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Lock Raven VA Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: none | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 2223 E. Chase Street | | 10f. ZIP CODE: 21213 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Negroid |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th grade; College (1-4 or 8+): none | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook | 16b. KIND OF BUSINESS/INDUSTRY: Government | |
| 17. FATHER'S NAME (First, Middle, Last): David C. Grandberry Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Carter | |
| 19a. INFORMANT'S NAME (Type/Print): Darlene Height | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2223 E. Chase St. Balto, Md. 21213 | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans | 20c. LOCATION — City or Town, State: Owingsmills, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs Sr. | | 22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | MULTI ORGAN SYSTEM FAILURE | 6 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | SEPSIS | 8 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | PERFORATED DUODENAL ULCER | 44 DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hemothorax. with Collapsed lung, left, massive

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year): 9/10/0 | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD 520307 | | 29c. LICENSE NUMBER: AU4635427 6W87 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/4/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGG WOLFF 738 MECHANIC STREET BALTO, MD. 21230 | | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | | |

DHMH-16 Rev 1/89

89 29795

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GENEVA GIBSON | | | | 2. DATE OF DEATH (Month, Day, Year): 11 - 04 - 1989 | 3. TIME OF DEATH: 1:00A M |
| 4. SOCIAL SECURITY NUMBER: 412-74-8814 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 44 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 03-07-1945 | 8. BIRTHPLACE (State or Foreign Country): Tennessee |
| 9a. FACILITY NAME (If not institution, give street and number): 3100 O'Donnell Street | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3100 O'Donnell Street | | 10f. ZIP CODE: 21224 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Packer | 16b. KIND OF BUSINESS/INDUSTRY: Montibello Brands | |
| 17. FATHER'S NAME (First, Middle, Last): Carl Cox | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dafnie Kennedy | |
| 19a. INFORMANT'S NAME (Type/Print): Ronald Gummer | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3100 O'Donnell St. Baltimore, MD 21224 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oak Lawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Elizabeth A. Dowell | | 22. NAME AND ADDRESS OF FACILITY: Lilly & Zeiler, Inc. Funeral Homes 700 South Conkling St. Balto. MD 21224 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | LUNG CANCER | 11 MONTHS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | TOBACCO USAGE | 20 YEARS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Linda A. Walsh MD | 29c. LICENSE NUMBER: D34208 | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/5/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LINDA A. WALSH 1012 OLD NORTH PT. RD, BALTIMORE, MD 21224 | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 29796

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page [illegible] should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE DEWEY GOODRICH JR. | | 2. DATE OF DEATH (Month, Day, Year): Nov. 1, 1989 | 3. TIME OF DEATH: 7:31 pM |
| 4. SOCIAL SECURITY NUMBER: 164-22-3632 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Feb. 14, 1929 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1936 Harkins Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Pylesville | 9c. COUNTY OF DEATH: Harford | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Pylesville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1936 Harkins Road | 10f. ZIP CODE: 21132 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): - - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY: Propane | |
| 17. FATHER'S NAME (First, Middle, Last): George Dewey Goodrich Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Elizabeth Archer | | |
| 19a. INFORMANT'S NAME (Type/Print): H. Genevieve Goodrich | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as #10 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Jarrettsville Cemetery | 20c. LOCATION — City or Town, State: Jarrettsville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Gladden Kurtz III | 22. NAME AND ADDRESS OF FACILITY: Kurtz Funeral Home Jarrettsville, Maryland 21084 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | cancer of the lung | aug 89 |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Pneumonia | aug 89 |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Perfecto C. Valarao | 29c. LICENSE NUMBER: D16389 | 29d. DATE SIGNED (Month, Day, Year) ▶ 11-2-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PERFECTO VALARAO M.D. 1716 Hanford Rd Fallston MD | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSALYN GOTTESMAN | | | | 2. DATE OF DEATH (Month, Day, Year): 11 / 1 / 89 | 3. TIME OF DEATH: 7:00 A M |
| 4. SOCIAL SECURITY NUMBER: 111 12 8311 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11/2/1915 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): 3814 Winchester Lane | | 9b. CITY, TOWN OR LOCATION OF DEATH: Bowie | | 9c. COUNTY OF DEATH: Prince George's | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Bowie | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER: 3814 Winchester Lane | | 10f. ZIP CODE: 20715 | | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker | | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Abraham Juskowitz | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ester Fuchs | | | |
| 19a. INFORMANT'S NAME (Type/Print): Cantor Samuel Gottesman | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3814 Winchester Lane, Bowie, Maryland 20715 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Lebanon Cemetery | | 20c. LOCATION — City or Town, State: Adelphi, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein | | 22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C. | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | ACUTE MYOCARDIAC INFARCTION | 15 MINUTES |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | ISCHEMIC HEART DISEASE | 20 YRS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | DIABETES MELLITUS | 20 YRS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | ADENOCARCINOMA UTERUS | 5 YRS |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D02153 | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3231 SUPERIOR LANE BOWIE 20715

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29798

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sister M. Marie Grady, R.S.M. | | 2. DATE OF DEATH (Month, Day, Year): 11 4 89 | 3. TIME OF DEATH: 335A M |
| 4. SOCIAL SECURITY NUMBER: 220-54-8310 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/26/11 |
| 8. BIRTHPLACE (State or Foreign Country): Massachusetts | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | |
| 10a. STATE: MD | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6806 Bellona Avenue | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): religious sister | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last): Leon Grady | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Hamilton | |
| 19a. INFORMANT'S NAME (Type/Print): Sr. Jogues Smith | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 11448 Balto. MD 21239 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Peter J. Ashton | 22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Estate, PA 736 Edmondson Ave. Balto. MD 21228 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. stomach perforation c peritonitis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. G tube placement | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND; 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify); 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| TRACY NIMMERRICHTER MD | | ▶ 11/4/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TRACY NIMMERRICHTER Mercy Hosp. Balt. Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV - 6 1989 NOV 6 1989 | Julia Davidson-Randolph |

DHMH-18 Rev 1/89

89 2792

89 29799

FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Fannie Goodman FANNIE EVA GOODMAN

**2. DATE OF DEATH** (Month, Day, Year): 11 - 01 - 89

**3. TIME OF DEATH**: 12:15 AM

**4. SOCIAL SECURITY NUMBER**: 218-07-9086

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 85 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 09-25-04

**8. BIRTHPLACE** (State or Foreign Country): MD

**9a. FACILITY NAME** (If not institution, give street and number): Levindale Hebrew Geriatric Center + Hospital

**9b. CITY, TOWN OR LOCATION OF DEATH**: Baltimore

**9c. COUNTY OF DEATH**:

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**:

**10c. CITY, TOWN OR LOCATION**: Baltimore

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 6514 PK HTS. AVE.

**10f. ZIP CODE**: 21215

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: X

**14. RACE — American Indian, Black, White, etc.**
Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 8
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): SALESPERSON

**16b. KIND OF BUSINESS/INDUSTRY**: RETAIL

**17. FATHER'S NAME** (First, Middle, Last): HARRY LOUIS FRIEDLANDER

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): SARA LEAH RIFKIN

**19a. INFORMANT'S NAME** (Type/Print): RICHARD GOODMAN

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2514 FLAGG MEADOW CT. FINKSBURG, MD 21048

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): BNAI ISRAEL

**20c. LOCATION — City or Town, State**: BALTIMORE, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Ellenore Levinson

**22. NAME AND ADDRESS OF FACILITY**: SOL LEVINSON & BROS., INC.
6010 REISTERSTOWN RD. BALTO., MD 21215

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PROBABLE UROSEPSIS — Approximate Interval: HOURS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. URINARY INCONTINENCE
DUE TO (OR AS A CONSEQUENCE OF):
c. END-STAGE ALZHEIMER'S DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Pending Investigation

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: A.J. Lucco ATTENDING MD

**29c. LICENSE NUMBER**: D30957

**29d. DATE SIGNED** (Month, Day, Year): ▶ 11-1-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): A.J. Lucco, MD 2434 W BELVEDERE AVE BALTIMORE 21215-5269

**31. DATE FILED** (Month, Day, Year): NOV 6 1989

**32. REGISTRAR'S SIGNATURE**: Gisha Davidson-Randall

DHMH-16 Rev 1/89

89 29800

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | MILDRED W HOUTZ | 2. DATE OF DEATH (Month, Day, Year) | NOV. 1, 1989 |
| 3. TIME OF DEATH | 5:00 P M | 4. SOCIAL SECURITY NUMBER | 211-18-3459 |
| 5. SEX | 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) | 91 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | | 7. DATE OF BIRTH (Month, Day, Year) | 04 08 1898 |
| 8. BIRTHPLACE (State or Foreign Country) | PA. | | |
| 9a. FACILITY NAME (If not institution, give street and number) | St Joseph's Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH | Baltimore City |
| 9c. COUNTY OF DEATH | Baltimore | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE | Md | 10b. COUNTY | Baltimore |
| 10c. CITY, TOWN OR LOCATION | Baltimore Maryland | 10d. INSIDE CITY LIMITS? | 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER | 624 Lake Avenue Baltimore Md | 10f. ZIP CODE | 21204 |
| 10g. CITIZEN OF WHAT COUNTRY? | USA | | |
| 11. MARITAL STATUS | 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: | WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | Elementary/Secondary (0-12): N/A; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | HOUSEWIFE |
| 16b. KIND OF BUSINESS/INDUSTRY | OWNHOME | | |
| 17. FATHER'S NAME (First, Middle, Last) | JAMES WELSH | 18. MOTHER'S NAME (First, Middle, Maiden Surname) | REBECCA WISE |
| 19a. INFORMANT'S NAME (Type/Print) | ALMETA W. SCHUNICK | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | 6853 QUEENS FERRY RD. BALTIMORE MD. 21239 |
| 20a. METHOD OF DISPOSITION | 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | MORELAND MEM. PARK |
| 20c. LOCATION — City or Town, State | BALTO.MD. 21234 | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | ▶ R.H. Rust | 22. NAME AND ADDRESS OF FACILITY | H.W.JENKINS AND SONS CO. 4905YORK RD. BALTO.MD21212 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ventricular fibrillation
DUE TO (OR AS A CONSEQUENCE OF):
b. acute MI
DUE TO (OR AS A CONSEQUENCE OF):
c. Severe coronary artery disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Thoracic + abdom aortic aneurysm
S/P CVA + cerebral emboli

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
| Joseph D'Antonio Jr. M.D. | | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
2401 Osler Drive Suite 210 Towson, Md. 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
| NOV 6 1989 | Gloria Davidson-Randall |

DHMH-16 Rev 1/89

89 29801

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ISABELLE W. HOPKINS | | | | | 2. DATE OF DEATH (Month, Day, Year): 11 01 1989 | 3. TIME OF DEATH: 7:46 P M |
| 4. SOCIAL SECURITY NUMBER: 216-40-0676 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 02/23/1914 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): G.B.M.C.-6701 N. CHARLES ST | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10a. STREET AND NUMBER: 2E GITTINGS AVE | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE | 16b. KIND OF BUSINESS/INDUSTRY: OWN HOME | |
| 17. FATHER'S NAME (First, Middle, Last): JAMES S. WHEDBEE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ELEANOR JENKINS | |
| 19a. INFORMANT'S NAME (Type/Print): ROGER B. HOPKINS JR. | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2 E. GITTING AVE. BALTIMORE MD.21212 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDERAL CEM. | 20c. LOCATION — City or Town, State: BALTIMORE MD.21229 |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R.H. Rut | | 22. NAME AND ADDRESS OF FACILITY: H.W.JENKINS AND SONS CO. 4905 YORK RD. BALTO.MD.21212 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarct | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: B. V. Joshi M.D. | 29c. LICENSE NUMBER: D20807 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 120 Seton Pierre Dr Towson 2124

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): 11/3/89 76 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 23001

89 29802

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): T. BRANNON HUBBARD JR. | | | | | 2. DATE OF DEATH (Month, Day, Year): NOV 1, 1989 | 3. TIME OF DEATH: 815P M |
| 4. SOCIAL SECURITY NUMBER: 420-44-4939 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): FEB. 5, 1918 | 8. BIRTHPLACE (State or Foreign Country): ALA. |
| 9a. FACILITY NAME (If not institution, give street and number): MERCY MED. CENTER | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | BALTIMORE | GARRISON | 1 ☐ YES 2 XX NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 305 GOLF COURSE RD. | 21055 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☐ NO — WW II | 1 ☐ YES 2 ☐ NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 5+ | SURGEN | MED. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| T. BRANNON HUBBARD SR. | CAROLYN CLARK |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| T. BRANNON HUBBARD III | 305 GOLF COURSE RD. GARRISON MD. 21055 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | GREENMT. CREMATORY | BALTIMORE MD. 21202 |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ R. H. Russ | H.W. JENKINS AND SONS CO. 4905 YORK RD. BALTIMORE MD. 21212 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARCINOMA OF PROSTATE — DUE TO (OR AS A CONSEQUENCE OF): | 6 YRS. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ARTERIOSclerotic heart Disease — DUE TO (OR AS A CONSEQUENCE OF): | 1 yr |
| | c. — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Joseph A. Mead Jr. MD | D 07080 | ▶ 11-1-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH A. MEAD JR. MD, 301 St Paul Pl. BALTIMORE 21202

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29803

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ELIJAH HILL | | 2. DATE OF DEATH (Month, Day, Year): 10/28/89 | 3. TIME OF DEATH: 10:20 P M |
| 4. SOCIAL SECURITY NUMBER: 225-05-0428 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 2/20/16 |
| 8. BIRTHPLACE (State or Foreign Country): Sanford, NC. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Liberty MED Center | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE MARYLAND | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince Georges | 10c. CITY, TOWN OR LOCATION: Mt. Rainier | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 4607 22nd Avenue | | 10f. ZIP CODE: 20712 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): -12- ; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Brick Mason | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Elijah Hill | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Lacey Dark | | |
| 19a. INFORMANT'S NAME (Type/Print): Jerri Houston - Niece | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4807 22nd Street Mt. Rainier, Maryland | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory | 20c. LOCATION — City or Town, State: Alexandria, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00690 ▶ Howard A Carson | 22. NAME AND ADDRESS OF FACILITY: House of Diggs 4906 Iverson Place, Hillcrest Heights, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arrythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ADVANCED Respiratory Insufficiency | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DIABETES | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Marie Davis MD | 29c. LICENSE NUMBER: D23760 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIE DAVIS 9141 BALT NAT PIKE ELLICOTT City Md 21043 | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 2803

89 29804

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary K. Hansen
2. DATE OF DEATH: Month: 11 Day: 3 Year: 89
3. TIME OF DEATH: 2 P. M
4. SOCIAL SECURITY NUMBER: 219-20-0943
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 83 YRS. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
7. DATE OF BIRTH (Month, Day, Year): 3/23/06
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Long Green Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 300A E. University Parkway
10f. ZIP CODE: 21218
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retirement clerk
16b. KIND OF BUSINESS/INDUSTRY: Baltimore City
17. FATHER'S NAME (First, Middle, Last): unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown
19a. INFORMANT'S NAME (Type/Print): James Jones
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Apt. 2A 361 Homeland Southway Balto. MD 21212
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory
20c. LOCATION — City or Town, State: Silver Spring, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roland P. Staub
22. NAME AND ADDRESS OF FACILITY: Walter Brooks Bradley, Inc. 2134 Willow Spring Rd. Balto. MD 21222

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Ventricular Fibrillation | Minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Coronary Artery Disease | 25 yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe Cardiovascular D. c Rt. Hemiparesis and Rt. Hemianopsia; Severe C.O.P.D.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William Benson M.D.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): W. BENSON 3506 N. CALVERT BALTIMORE, MD. 21218
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall

DNMN-16 Rev 1/89

89 29805

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ANNA S. Hecht | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 2:30A M |
| 4. SOCIAL SECURITY NUMBER: 172-36-9853 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): JUNE 21, 1901 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3115-B BANCROFT RD. | | 10f. ZIP CODE: 21215 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced XX | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUYER | 16b. KIND OF BUSINESS/INDUSTRY: DEPARTMENT STORE | |
| 17. FATHER'S NAME (First, Middle, Last): JACOB SHAPIRO | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DORA ROSENBERG | |
| 19a. INFORMANT'S NAME (Type/Print): RICHARD HECHT | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8809 MAYWOOD AVE SILVER SPRING, MD 20910 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. MORIAH | 20c. LOCATION — City or Town, State: HARRISBURG, PA. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sydney L. Stellman | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Aspiration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Edmund P. Ikaczuk MD | 29c. LICENSE NUMBER: D34951 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EDMUND P. IKACZUK | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: [illegible] | |

DHMH-16 Rev 1/89

89 29806

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PHYLLIS GEORGIA HELMICK | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 30, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215-30-1194 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-5-1933 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): 7827 SCHOLAR ROAD | | 9b. CITY, TOWN OR LOCATION OF DEATH: DUNDALK | | 9c. COUNTY OF DEATH: BALTIMORE |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7827 SCHOLAR ROAD | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): UNKNOWN | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FACTORY WORKER | 16b. KINO OF BUSINESS/INOUSTRY: FOOD | |
| 17. FATHER'S NAME (First, Middle, Last): UNKNOWN STEPIK | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN | |
| 19a. INFORMANT'S NAME (Type/Print): GARY L. HELMICK | 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7827 SCHOLAR ROAD BALTIMORE, MARYLAND 21222 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetary, crematory or other place): CEDAR HILL CEMETERY NOV. 1, 1989 | 20c. LOCATIDN — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MARYLAND 21222 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions that caused the death. Do not antar the moda of dying, such as cardiac or reapiratory arrest, shock, or heart failura. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARRHYTHMIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST | b. ORGANIC HEART DISEASE | 8 YEARS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PACEMAKER, HIGH BLOOD PRESSURE, CEREBROVASCULAR DISEASE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME DF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. OESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(e) and manner ee stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D31189 | 29d. DATE SIGNED (Month, Day, Year): ▶ OCTOBER 30, 1989 |
| 30. NAME AND ADDRESS OF PERSDN WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL J. MININSOHN, M.D., 3509 EASTERN AVE., BALTIMORE, MD. 21224 | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29807

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CHARLES INGRAO | | | 2. DATE OF DEATH (Month, Day, Year): OCT. 31, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 108 05 5980 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 1, 1902 | 8. BIRTHPLACE (State or Foreign Country): Florida |
| 9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Olney | | 9c. COUNTY OF DEATH: Montgomery |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Silver Spring | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 13215 Rippling Brook Drive | | 10f. ZIP CODE: 20901 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Spray Painter | 16b. KIND OF BUSINESS/INDUSTRY: Private Firm |
| 17. FATHER'S NAME (First, Middle, Last): Nicholas Ingrao | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Concetta Enserro | |
| 19a. INFORMANT'S NAME (Type/Print): Nicholas Ingrao | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as #10 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mo. Olivet Cemetery | 20c. LOCATION — City or Town, State: Falconer, NY |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes Arlington, Va. 22201 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. RENAL FAILURE | ONE WEEK |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. NEPHROSCLEROSIS & EMBOLISM | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. PROSTATIC CARCINOMA | 3 Yrs or Longer |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: R.A. Matheus, MD | 29c. LICENSE NUMBER: D18924 | 29d. DATE SIGNED (Month, Day, Year): ▶ OCTOBER 31, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAFAEL MATHEUS, M.D. 13,018 GEORGIA AVENUE SILVER SPRING, MD.20906

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas L. Jennings
2. DATE OF DEATH (Month, Day, Year): 11 5 89
3. TIME OF DEATH: 1:27 AM
4. SOCIAL SECURITY NUMBER: 216-10-1552
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-12-18
8. BIRTHPLACE (State or Foreign Country): USA
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1100 PENNSYLVANIA AVENUE APT. 1503
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): UNKNOWN — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SCAPER BUILDER
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): STEVEN JENNINGS
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE JEFFERSON
19a. INFORMANT'S NAME (Type/Print): MILLIE OLIVER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1902 EAST 31st. STREET/BALTIMORE, MD 21218
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARBUTUS MEM. PK. CEM.
20c. LOCATION — City or Town, State: ARBUTUS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Julia R. March
22. NAME AND ADDRESS OF FACILITY: WM.C. MARCH F.H. 1101 E. NORTH AVE.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: S Robinson MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): UMMS 22 S. Greene St. Balto Md 21201
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kindell

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HUBERT JOYNER | | | 2. DATE OF DEATH (Month, Day, Year): NOVEMBER 2, 1989 | 3. TIME OF DEATH: 2:51P M |
| 4. SOCIAL SECURITY NUMBER: 212-36-7418A | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 69 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-24-20 | 8. BIRTHPLACE (State or Foreign Country): NC |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 408 N. PATTERSON PARK AVENUE | | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER | 16b. KIND OF BUSINESS/INDUSTRY: NA | |
| 17. FATHER'S NAME (First, Middle, Last): ONNIE JOYNER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CANDY | |
| 19a. INFORMANT'S NAME (Type/Print): HEATHER JOYNER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 N. PATTERSON PARK AVE., BALTO., MD 21231 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN CEMETERY | 20c. LOCATION — City or Town, State: WOODLAWN, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gladys Warner | 22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVE. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular fibrillation | 10 minutes |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Coronary artery disease | 10 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶11/4/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mark Haigney 600 N Wolfe St Baltimore | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Arnold JANNEY JR. | | | 2. DATE OF DEATH (Month, Day, Year): October 31, 1989 | 3. TIME OF DEATH: 3:25pM |
| 4. SOCIAL SECURITY NUMBER: 407-28-9402 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): April 23, 1926 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Sq. Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Joppa | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1618 Dugan Dr. | | 10f. ZIP CODE: 21085 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1944-1946 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): llyrs. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance | 16b. KIND OF BUSINESS/INDUSTRY: Bethlehem Steel | |
| 17. FATHER'S NAME (First, Middle, Last): Arnold Janney Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alpha Elkins | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Betty J. Janney | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1618 Dugan Dr. joppa, Md.21085 | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Belair Memorial Gardens | 20c. LOCATION — City or Town, State: Bel Air, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. F. Lassahn | | 22. NAME AND ADDRESS OF FACILITY: E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville,Md. 21087 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Bone carcinoma with metastases. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul Wielebinski MD | D033719 | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul Wielebinski, M.D. 9000 Franklin Square Dr., Balto., 21237

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

Items 10a,10b, 10e,10f 12-1-89 FilmG658 W.H.

89 29811

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): IRVIN KOVENS
2. DATE OF DEATH (Month, Day, Year): 10-31-1989
3. TIME OF DEATH: 6:35 AM
4. SOCIAL SECURITY NUMBER: 212-12-6482
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): OCT 20, 1918
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

1. ~~MARYLAND~~ Florida
10b. COUNTY:
1c: ~~BALTIMORE~~ Bal Harbour
10d. INSIDE CITY LIMITS? XX 1 [ ] YES 2 [ ] NO
1: ~~3601 CLARKS LANE, APT. PH-F~~ 10155 Collins Ave Apt 1805 — ~~21215~~ 33154
10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MERCHANT
16b. KIND OF BUSINESS/INDUSTRY: RETAIL

17. FATHER'S NAME (First, Middle, Last): MORRIS KOVENS
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA MARGOLIN

19a. INFORMANT'S NAME (Type/Print): MRS. JACQUELINE KOVENS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3601 CLARKS LA, APT. PH-F BALTO., MD 21215

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH JACOB
20c. LOCATION — City or Town, State: FINKSBURG, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harry D Levinson
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on aach lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIAC ARREST | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Congestive Heart Failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | RENAL INSUFFICIENCY | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E D Wall
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 10/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randolph

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29811

89 29812

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GEORGE W. KNIPP | | | 2. DATE OF DEATH (Month / Day / Year): 11 / 2 / 89 | 3. TIME OF DEATH: 8:10 p.m. |
| 4. SOCIAL SECURITY NUMBER: 242-58-5723 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1/3/07 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Holly Hill Manor | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO |
| 10e. STREET AND NUMBER: 6407 Pinehurst Rd. | | 10f. ZIP CODE: 21212 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): College English Professor | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Walter Knipp | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Heubeck | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Helen Knipp | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6407 Pinehurst Rd. Baltimore, Md. 21212 | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert M. Kratz | | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home Inc. 6500 York Rd. 21212 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CVA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic cardiovascular | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. urinary tract infection | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D07430 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HANS J. KOETTER MD 7600 Osler Drive Towson 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: [signature] |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lyle F. Lillibridge | | | 2. DATE OF DEATH MONTH DAY YEAR: 11-2-89 | 3. TIME OF DEATH: 1:35PM M |
| 4. SOCIAL SECURITY NUMBER: 217-24-4676 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1-10-29 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: ====== |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: ====== | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 3818 Pennington Avenue | | 10f. ZIP CODE: 21226 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Security Guard | 16b. KIND OF BUSINESS/INDUSTRY: Security |
| 17. FATHER'S NAME (First, Middle, Last): Roy Lillibridge | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Fuller | |
| 19a. INFORMANT'S NAME (Type/Print): James Hoover | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2105 Schuster Road Jarrettsville, Maryland 21085 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C Davis | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused tha death. Do not enter the moda of dying, such as cerdisc or respiratory arrest, shock, or hasrt failure. List only ona ceuse on aach lina.

| | | Approximata Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finsl disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immedieta cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [XX] NO INSPECTION | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES [XX] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [XX] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [XX] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. md | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-3-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., MD | 111 Penn Street, Baltimore, MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall | |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ROSS LESHER | | 2. DATE OF DEATH (Month, Day, Year): Oct. 27, 1989 | 3. TIME OF DEATH: 8:28 pm M |
| 4. SOCIAL SECURITY NUMBER: 204-26-8665 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 2-12-1906 |
| 8. BIRTHPLACE (State or Foreign Country): Penna. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Avalon Home Inc. | 9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown | 9c. COUNTY OF DEATH: Washington | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Penna. | 10b. COUNTY: Franklin | 10c. CITY, TOWN OR LOCATION: Greencastle | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 12710 Grant Shook Road | 10f. ZIP CODE: 17225 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | 16b. KIND OF BUSINESS/INDUSTRY: Agriculture | |
| 17. FATHER'S NAME (First, Middle, Last): Jacob G. Lesher | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Estella Hollinger | | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret Lesher | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12710 Grant Shook Road Greencastle, Penna. 17225 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Greencastle, Penna. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: Harold M. Zimmerman and Son Funeral Home 45 South Carlisle St. Greencastle, Pa. 17225 | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio-Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia, viral / Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. / Arteriosclerotic Heart Disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. / Arteriosclerosis, gen | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.

29c. LICENSE NUMBER: D0 42402

29d. DATE SIGNED (Month, Day, Year): ▶ 28 Oct. 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 138 E. Antietam St. Hagerstown, MD 21740

31. DATE FILED (Month, Day, Year): NOV 6 '89

32. REGISTRAR'S SIGNATURE: Lisha Davidson

DHMH-16 Rev 1/89

89 29815

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Dock Randolph Lewis | | | 2. DATE OF DEATH: MONTH 11-2-89 DAY YEAR | 3. TIME OF DEATH: 5:50PM M |
| 4. SOCIAL SECURITY NUMBER: 217-38-3558 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-15-32 | 8. BIRTHPLACE (State or Foreign Country): South Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): 2038 E. Baltimore Street | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: none |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: none | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2038 E. Baltimore Street | | 10f. ZIP CODE: 21231 | 10g. CITIZEN OF WHAT COUNTRY?: United States |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Negroid |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+): unknown | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Butcher | 16b. KIND OF BUSINESS/INDUSTRY: Dukeland Packing Co. | |
| 17. FATHER'S NAME (First, Middle, Last): unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mollie Lewis | |
| 19a. INFORMANT'S NAME (Type/Print): Mollie Lewis | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2038 E. Baltimore, Street Balto, Md. 21231 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Calavary Cemetery | 20c. LOCATION — City or Town, State: Anne Arundal Co, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Calvin B. Scruggs Sr. | | 22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cirrhosis and fatty liver

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Chronic ethanol abuse

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☒ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr MD | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.MD — 111 Penn Street, Baltimore, MD 21201 VC

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson |

DHMH-16 Rev 1/89

89 29815

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CARLO BRUCE LEE
2. DATE OF DEATH (Month, Day, Year): 11 04 89
3. TIME OF DEATH: 23:00 M
4. SOCIAL SECURITY NUMBER: 218-92-6365
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 14 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 06-09-75
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY HOSP. TRAUMA 22 GREENE ST.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTO. MD.
9c. COUNTY OF DEATH: NONE

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: NONE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 1034 Cameron Rd.
10f. ZIP CODE: 21239
10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negroid
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Student
16b. KIND OF BUSINESS/INDUSTRY: Middle School
17. FATHER'S NAME (First, Middle, Last): Arthur Lee
18. MOTHER'S NAME (First, Middle, Maiden Surname): Elaine Bowie
19a. INFORMANT'S NAME (Type/Print): Elaine Lee
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5300 Leith (Apt. C) Rd. Balto. Md. 21239
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Arbutus Mem. Park
20c. LOCATION — City or Town, State: Balto, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs, II
22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home 21213, 1412 E. Preston St. Baltimore, Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Adult Respiratory Distress syndrome — DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Multiple trauma — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Disseminated intravascular coagulation

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 10/26/89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: Car Accident
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Bekele Afessa, M.D.
29c. LICENSE NUMBER: D35997
29d. DATE SIGNED (Month, Day, Year): 11/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bekele Afessa, M.D. 225. Greene Street Baltimore
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Ritchie

DHMH-16 Rev 1/89

89 29816

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ada Logan V.
2. DATE OF DEATH (Month, Day, Year): 11 4 89
3. TIME OF DEATH: 6 00 A M
4. SOCIAL SECURITY NUMBER: 229-07-2447
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 96 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-4-1893
8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): Mercy Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 607 Pennsylvania Ave.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: B
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY: Private
17. FATHER'S NAME (First, Middle, Last): Jefferson Davis
18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Jackson
19a. INFORMANT'S NAME (Type/Print): Howard Gillis
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2107 N. Washington St. Balto., Md 21213
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randolph J. Collick
22. NAME AND ADDRESS OF FACILITY: Collick F.H. 2431 E. Oliver St. Baltimore, Md 21213

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metabolic Acidosis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):

c. Chronic renal failure

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward Lee MD Intern
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year):
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 301 St Paul Place Mercy Medical Center Balt. Md. 21202
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kinard

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN J. LUNCZYNSKI
2. DATE OF DEATH (Month, Day, Year): 11 5 89
3. TIME OF DEATH: 12:15 PM
4. SOCIAL SECURITY NUMBER: 216-20-0002
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 40 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/25/49
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Harbor Hosp. Center
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH: Md.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1455 Hull St.
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 5/6/69 - 5/5/73
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th yr. — College (1-4 or 5+): —
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter
16b. KIND OF BUSINESS/INDUSTRY: Contractor
17. FATHER'S NAME (First, Middle, Last): Teodore J. Lunczynski
18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Gilson
19a. INFORMANT'S NAME (Type/Print): Shawn Queen
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6800 B. North Charles Rd. Glen Burnie Md.
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cem.
20c. LOCATION — City or Town, State: Dundalk Md. 21061
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stanley Doba
22. NAME AND ADDRESS OF FACILITY: Charles L. Steves Funeral Home 1701 E 33rd Ave.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. APLASTIC ANEMIA
DUE TO (OR AS A CONSEQUENCE OF):
b. PANCYTOPENIA
DUE TO (OR AS A CONSEQUENCE OF):
c. HEPATIC CIRRHOSIS
DUE TO (OR AS A CONSEQUENCE OF):
d. JAUNDICE + ASCITES

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
SEIZURES
ELECTROLYTE IMBALANCE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] AS-2441614-25
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11-5-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DANIEL ROSLER HARBOR HOSP. CENTER.
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29818

89 29819

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) ~~LUSTGARTEN~~ ROSE ~~ROSE~~ LUSTGARTEN | | | | 2. DATE OF DEATH MONTH 11 DAY 1 YEAR 89 | 3. TIME OF DEATH 12:25 P.M. |
| 4. SOCIAL SECURITY NUMBER 065-09-0550 | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) APRIL 8, 1900 | 8. BIRTHPLACE (State or Foreign Country) NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number) HOMEWOOD HOSPITAL CENTER SOUTH | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE | | 9c. COUNTY OF DEATH |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE MARYLAND | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION BALTIMORE | 10d. INSIDE CITY LIMITS? XX 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER 2500 W. BELVEDERE AVE, APT. 507 | | 10f. ZIP CODE 21215 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER | 16b. KIND OF BUSINESS/INDUSTRY AT HOME |
| 17. FATHER'S NAME (First, Middle, Last) JACOB KAMMERMAN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) EVA LOSHINSKY | |
| 19a. INFORMANT'S NAME (Type/Print) MARILYN YOURDIS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8835 WINTERBROOK RD. RANDALLSTOWN, MD 21133 | |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BETH MOSES | 20c. LOCATION — City or Town, State PINELAWN, NEW YORK |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Sydney H. Stillman | | 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARRYTHMIA & CARDIAC ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. PSORIASIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 26d. DESCRIBE HOW INJURY OCCURED | | |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER A.C. Chennalit, M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/1/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HOMEWOOD HOSPITAL CENTER | | |
| 31. DATE FILED (Month, Day, Year) NOV 6 1989 | 32. REGISTRAR'S SIGNATURE Gloria Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29820

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be detached for use as the burial-transit permit, Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Zofia Latajka | | | 2. DATE OF DEATH (Month, Day, Year): Nov. 04, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 215-32-3932 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Nov. 06, 1920 | 8. BIRTHPLACE (State or Foreign Country): Poland |
| 9a. FACILITY NAME (If not institution, give street and number): St. John's Nursing Home | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md | 10b. COUNTY: Baltimore City | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 227 S. Ellwood Ave. | | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress | | 16b. KIND OF BUSINESS/INDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last): Unknown Piotrowski | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Halina Maliszewski | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2032 Fallsgrove ~~Baltimore~~ FALLSTON Md 21047 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stanislaus Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward J. Weber | | 22. NAME AND ADDRESS OF FACILITY: Edward J. Weber FH 401 S. Chester St. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Aortic Stenosis with Mitral Valve Regurgitation
DUE TO (OR AS A CONSEQUENCE OF):
d. Diabetes Mellitus Type II

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypertension, Congestive Heart Failure,

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | D37949 | ▶ 11-6-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alexander Bodaszewsky, MD. Ruxton Towers Suite #212, 8415 Bellona Lane Towson MD. 21204

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sonny JAMES Lowery II | | | 2. DATE OF DEATH (Month, Day, Year): 11-2-89 | 3. TIME OF DEATH: 6:30PM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 11 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-27-77 | 8. BIRTHPLACE (State or Foreign Country): MD. |
| 9a. FACILITY NAME (If not institution, give street and number): Johns Hopkins Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: — | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 2503 JEFFERSON ST. | | 10f. ZIP CODE: 21205 | 10g. CITIZEN OF WHAT COUNTRY? USA, |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: AMER. INDIAN |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5TH; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED | 16b. KIND OF BUSINESS/INDUSTRY: — | |
| 17. FATHER'S NAME (First, Middle, Last): SONNY J. LOWERY JR, | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DEBORAH E. LOAR | | |
| 19a. INFORMANT'S NAME (Type/Print): SONNY J. LOWERY | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2503 JEFFERSON ST. BALTO, MD. 21205 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GLEN HAVEN CEM. | 20c. LOCATION — City or Town, State: GLEN BURNIE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David D. Weber | 22. NAME AND ADDRESS OF FACILITY: EDWARD J. WEBER F.H. 401 S. CHESTER ST. | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Hanging | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? XX YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 XX Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☒ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 11-2-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES XX ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject hanged self |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2503 E. Jefferson St.Balto.,MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D. | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-3-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,MD | 111 Penn Street,Baltimore,MD 21201 | VC |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Linda Randall | |

DHMH-18 Rev 1/89

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89 29822

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed before forwarding to the funeral director. Page 5 should be detached by the funeral director; page 5 should be detached by you as the burial permit, page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified of also

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY GIRL MULLEN (Casey Nicole Mullen)
2. DATE OF DEATH (Month, Day, Year): OCTOBER 30, 1989
3. TIME OF DEATH: 8:39A M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS: 15 — IF UNDER 24 HRS.: HOURS — MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-15-89
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: =====

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: ======
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2727 Marbourne Avenue
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): William Richard Mullen
18. MOTHER'S NAME (First, Middle, Maiden Surname): Carolyn Sue McConkey
19a. INFORMANT'S NAME (Type/Print): Gloria Adams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7734 Woodlawn Avenue Pasadena, Maryland 21122
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory, Inc.
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donna M Bramionoshi
22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | GRAM NEGATIVE SEPSIS | 2 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | OMPHALOCELE | 14 day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | DIAPHRAGMATIC HERNIA; PULMONARY HYPERTENSION | 14 days |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RENAL FAILURE
RESPIRATORY FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Karen Blender MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ Oct-30-1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KAREN BLENDER JOHNS HOPKINS HOSPITAL Baltimore Md 21234
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

89 29823

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): McFADDEN EUGENE
2. DATE OF DEATH (Month, Day, Year): OCT 31 1989
3. TIME OF DEATH: 1036 AM
4. SOCIAL SECURITY NUMBER: 578 16 5691
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAR 1 1914
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): SINAI HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE City
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALT. CITY
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5304 NELSON AVE
10f. ZIP CODE: 21215
10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: UNK
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Steel-worker
16b. KIND OF BUSINESS/INDUSTRY: PLANT / Production

17. FATHER'S NAME (First, Middle, Last): WILLIAM McFADDEN
18. MOTHER'S NAME (First, Middle, Maiden Surname): ADDIE WILSON.

19a. INFORMANT'S NAME (Type/Print): M. CHART
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western Star Cemetery
20c. LOCATION — City or Town, State: Baltimore

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willie Parran
22. NAME AND ADDRESS OF FACILITY: Carolina Funeral Service

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST — 2 min
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Metastatic Cancer
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: AM176435 (19)92
29d. DATE SIGNED (Month, Day, Year): 31 Oct 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER M DAGONI SR MD

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29824

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): CLEE MEADOWS
2. DATE OF DEATH (Month, Day, Year): 10- 30- 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 236-40-0643
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.)
7. DATE OF BIRTH (Month, Day, Year): 12-01-1910
8. BIRTHPLACE (State or Foreign Country): VIRGINA
9a. FACILITY NAME (If not institution, give street and number): ARUNDEL GERIATRIC NURSING HOME
9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE
9c. COUNTY OF DEATH: MARYLAND

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: GLEN BURNIE
10c. CITY, TOWN OR LOCATION:
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 7355 FURNANCE BRANCH ROAD
10f. ZIP CODE: 21061
10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): LANE MARTIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): GEORGIANNA GARRETT
19a. INFORMANT'S NAME (Type/Print): LEILAN M. Cleeke LELA CLARK
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1319 KENNEDY STREET N.W. WASHINGTON D.C. -20011-
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ARLINGTON NATIONAL
20c. LOCATION — City or Town, State: ARLINGTON, VA.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ IRVIN CARROLL
22. NAME AND ADDRESS OF FACILITY: 1712 W. NORTH AVE. BALTIMORE MARYLAND 2217

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA

DUE TO (OR AS A CONSEQUENCE OF): CVD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] M.D.
29c. LICENSE NUMBER: D-19528
29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ELWOOD A. DAYOSO, M.D. 5411 Old Frederick Road Balto. Md. 21229

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29825

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles MASTRECOLA | | | 2. DATE OF DEATH (Month / Day / Year): 11 2 1989 | 3. TIME OF DEATH: 6:15 A M |
| 4. SOCIAL SECURITY NUMBER: 216-03-9216 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): June 13,1915 | 8. BIRTHPLACE (State or Foreign Country): MAryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Md. | 10b. COUNTY: BAltimore | 10c. CITY, TOWN OR LOCATION: Middle River | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 64 West Kingston Park Lane | | 10f. ZIP CODE: 21220 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dispatcher | | 16b. KIND OF BUSINESS/INDUSTRY: Anchor Motor Fright |
| 17. FATHER'S NAME (First, Middle, Last): Micheal Mastrecola | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Lightner | | |
| 19a. INFORMANT'S NAME (Type/Print): Marie Mastrecola | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 64 West Kingston Park Lane Balto. Md. 21220 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sacred Heart of Jesus Cemetery | | 20c. LOCATION — City or Town, State: BAltimore Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Connelly Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: Connelly Funeral Home 300MAceAve. 21221 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CHRONIC RESTRICTIVE AIRWAY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. RT. MIDDLE LOBE PNEUMONIA<br>DUE TO (OR AS A CONSEQUENCE OF): | |
| | c.<br>DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ISCHEMIC HEART DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: [X] 1 Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD. | D 16728 | ▶ 11-02-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bo Zaw-Win,M.D. 6660 Belair Road, Baltimore MD 21206

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 11-02-89 NOV 6 1989 | Julie Davidson-Randall |

DHMH-16 Rev 1/89

89 29826

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY F. NICKERSON | | | 2. DATE OF DEATH: MONTH 10 DAY 31 YEAR 89 | 3. TIME OF DEATH: 12:00 AM |
| 4. SOCIAL SECURITY NUMBER: 218-26-4279 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06/24/29 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER | | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Perry Hall | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 9400 DAWNVALE ROAD BALTIMORE MD | | 10f. ZIP CODE: 21236 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+): 5 years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Guidance Chairman | 16b. KIND OF BUSINESS/INDUSTRY: Kenwood High School | |
| 17. FATHER'S NAME (First, Middle, Last): Paul J. Fischer | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Smith | |
| 19a. INFORMANT'S NAME (Type/Print): Frederick Nickerson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9400 Dawnvale Rd. Balto., Md. 21236 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lassahn Funeral Home | | 22. NAME AND ADDRESS OF FACILITY: Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. METASTATIC RECURRENT OVARIAN CANCER | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiorespiratory Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SMALL BOWEL OBSTRUCTION

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Howard C. Rosenstein | 29c. LICENSE NUMBER: D20637 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-31-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. ROSENSTEIN G.B.M.C 6701 N. CHARLES STREET TOWSON MD 21204

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29826

89 29827

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

24

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie S. Naylor
2. DATE OF DEATH: MONTH 10 DAY 31 YEAR 89
3. TIME OF DEATH: 4:45 AM
4. SOCIAL SECURITY NUMBER: 220-50-1091
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 87 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-24-02
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Meridian Multi Medical
9b. CITY, TOWN OR LOCATION OF DEATH: Towson, Md.
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: Monkton
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 15306 Carroll Rd.
10f. ZIP CODE: 21111
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Homemaker
17. FATHER'S NAME (First, Middle, Last): Edward John Schroeder
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Louise Hollands
19a. INFORMANT'S NAME (Type/Print): Lamar C. Naylor
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15306 Carroll Rd. Monkton, Md. 21111
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lassahn Funeral Home Inc.
22. NAME AND ADDRESS OF FACILITY: Lassahn Funeral Home, 7401 Belair Rd. Balto., Md. 21236

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of Urinary Bladder with widespread metastasis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus

c. DUE TO (OR AS A CONSEQUENCE OF): Hypertension.

d.

PART II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I.: Dehydration -

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Pending Investigation

28a. DATE OF INJURY (Month, Day, Year): —
28b. TIME OF INJURY: — M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: —
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): —
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): —

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D29052
29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Vaseem Malik (337-7676) St. Jos. Hospital Towson, Maryland

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29827

89 29828

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clement J. Oliver
2. DATE OF DEATH (Month, Day, Year): Nov. 3 89
3. TIME OF DEATH: 0450 AM
4. SOCIAL SECURITY NUMBER: 218-18-5747
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-11-23
8. BIRTHPLACE (State or Foreign Country): VA.
9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1111 ORLEANS STREET
10f. ZIP CODE: 21202
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Elementary — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER
16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): GEORGE OLIVER
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY FRANCIS SMITH
19a. INFORMANT'S NAME (Type/Print): EVELYN OLIVER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 ORLEANS STREET/BALTIMORE, MD. 21202
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARYLAND NATIONAL PK. CEM
20c. LOCATION — City or Town, State: LAUREL, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Julia R. March
22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F.H. 1101 E. NORTH AVE.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ileus | 4 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Right Lower Lobe Pneumonia | 5 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Motor Vehicle Accident | 20 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: J. Harold, M.D., Intern, Medicine Service
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): Nov. 3, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Harold M.D. Mercy Hospital St Paul Pl. Ba Ho. Md.
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29829

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

15

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DILLON CLIFTON PARKS | | | 2. DATE OF DEATH (Month, Day, Year): 10/28/1989 | 3. TIME OF DEATH: 5:30PM M |
| 4. SOCIAL SECURITY NUMBER: 235603293 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 75 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Apr. 23, 1914 | 8. BIRTHPLACE (State or Foreign Country): W.Va. |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | 9c. COUNTY OF DEATH: ALLEGANY COUNTY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: W.Va. | 10b. COUNTY: Grant | 10c. CITY, TOWN OR LOCATION: Scherr | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Box 172 | | 10f. ZIP CODE: 26726 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher-Administration | 16b. KIND OF BUSINESS/INDUSTRY: Public School System |
| 17. FATHER'S NAME (First, Middle, Last): James M. Parks | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Muntzing | |
| 19a. INFORMANT'S NAME (Type/Print): Robert C. Parks | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Stirrup Drive Newburg, N.Y. 12250 | |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maysville Cemetery | 20c. LOCATION — City or Town, State: Maysville, W.Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allen M. Rotruck | 22. NAME AND ADDRESS OF FACILITY: Rotruck Funeral Home 85 S. Main St. Keyser, W.Va. 26726 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure — 3 years
DUE TO (OR AS A CONSEQUENCE OF):
b. Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c. Coronary Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe COPD

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY M | 26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 26d. DESCRIBE HOW INJURY OCCURED |
| | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Richard G Schmitt MD | 29c. LICENSE NUMBER: D26333 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
RICHARD SCHMITT, M.D. SACRED HEART HOSPITAL, CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall |

DHMH-16 Rev 1/89

89 29830

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen M. Roycroft ( HELEN M. ROYCROFT)
2. DATE OF DEATH — MONTH: NOV. DAY: 1 YEAR: 1989
3. TIME OF DEATH: 4:30 A M
4. SOCIAL SECURITY NUMBER: 220-44-2126
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug 18, 1903
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Church Home 101 N. Bond St.
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE, MARYLAND
9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 312 Eastway Ct.
10f. ZIP CODE: 21212
10g. CITIZEN OF WHAT COUNTRY? U.S.A
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Home Maker
16b. KIND OF BUSINESS/INDUSTRY: Own home
17. FATHER'S NAME (First, Middle, Last): Jacob Mertel
18. MOTHER'S NAME (First, Middle, Maiden Surname): KATERINA HERGENROEDER
19a. INFORMANT'S NAME (Type/Print): Mrs. Walter James
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5412 Purlington Way Balimore, Md. 21212
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ E. M. Perkins
22. NAME AND ADDRESS OF FACILITY: Henry W. Jenkins Funeral Home 4905 York Rd. Balto. Md. 21212

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute CVA
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) CHURCH HOME
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation e ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D37233
29d. DATE SIGNED (Month, Day, Year): ▶ 11-01-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH HUBAYKAH
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29831

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Margaret V. Small | | 2. DATE OF DEATH (Month, Day, Year): 11 05 89 | 3. TIME OF DEATH: 830A M |
| 4. SOCIAL SECURITY NUMBER: 213-16-4652 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 10-22-06 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): HomewoodHospital Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 600 Light Street, Apt. 329 | | 10f. ZIP CODE: 21230 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): Norman F. Small, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Lee Bell | |
| 19a. INFORMANT'S NAME (Type/Print): Beverly Barrett | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 138 Sandy Beach Drive Pasadena, MD 21122 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Cemetery | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. Alex Coleman | 22. NAME AND ADDRESS OF FACILITY: Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO PULM ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. 2° to ? SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. 2° to ? ASPIRATION PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. N/K IDDM | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/05/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD 4e HOMEWOOD HOSP. CTR. 2724 N. CHARLES ST. BALTIMORE, MD 21218

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Lidia Davidson-Randall |

DHMH-18 Rev 1/89

89 29832

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|
| Loretta A. Strumsky | 11 / 4 / 89 | 11 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-30-4879 | 1 ☐ M 2 ☒ F XX | 78 YRS. | | | 4-6-11 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 531 Shipley Road | Linthicum | Anne Arundel |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Lansdowne | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3327 James Street | 21227 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 9th grade | | Cook | Wade's Cafe |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Samuel Breighner | Mary UNKNOWN |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Frank J. Strumsky, Jr. | 531 Shipley Road Linthicum, MD 21090 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Meadowridge Memorial Park | Elkridge, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Teresa L. Groff | Hubbard Funeral Home, Inc. 4107 Wilkens Ave. Baltimore, MD 21229 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Superior Vena Cava Syndrome DUE TO (OR AS A CONSEQUENCE OF): | 1 wk |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Progressive nodular lymphoma DUE TO (OR AS A CONSEQUENCE OF): | 2 years |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Paul Gormley | D18587 | ▶ 11/6/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Paul Gormley, M.D. St. Agnes Hospital Oncology Dept. Balto., MD 21229

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Taylor Rankin |

DNMN-16 Rev 1/89

Items:23 thru 28f per ME G-657
11-17-89 cm

89 29833

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): David Sanford | | | | 2. DATE OF DEATH: MONTH 10 DAY 20 YEAR 89 | 3. TIME OF DEATH: 8:15 PM |
| 4. SOCIAL SECURITY NUMBER: 214-78-2846 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 25 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 12 30 63 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): University Hospital Shock Trauma | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: | |
| RESIDENCE OF DECEDENT | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10e. STREET AND NUMBER: 27 N. Fulton Avenue | | 10f. ZIP CODE: 21223 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance Worker | | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Gilbert Sanford | | 18. MOTNER'S NAME (First, Middle, Maiden Surname): Carrie Baker | | | |
| 19a. INFORMANT'S NAME (Type/Print): Carrie Carter | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 N. Fulton Avenue Baltimore, Md 21223 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Western star Cemetary | | 20c. LOCATION — City or Town, State: Catonsville, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Harris | | 22. NAME AND ADDRESS OF FACILITY: Marshall P. Hayes F/H | | 638 N. Gilmor St. Balto., Md 21217 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Complications of cocaine intoxication | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC INTRAVENOUS NARCOTISM AND CARDIOMEGALY

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 6 [ ] Residence 8 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [X] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): 10-14-89 | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO | 28d. DESCRIBE HOW INJURY OCCURED: UNKNOWN |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): FOUND: STREET | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 2500 W Franklin St. Baltimore City, Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D. 111 Penn St. Balto., Md. 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ITEM:23pt2 per ME G-659 1-19-90 cm
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29834

3

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN SCRUGGS
2. DATE OF DEATH (Month, Day, Year): NOVEMBER 4, 1989
3. TIME OF DEATH: 12:00 P M
4. SOCIAL SECURITY NUMBER: 216-24-7021
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 07-30-32
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: none
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2030 Hoffman Street
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Negroid
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade — College (1-4 or 5+): none
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unemployed
16b. KIND OF BUSINESS/INDUSTRY: none
17. FATHER'S NAME (First, Middle, Last): unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Scruggs
19a. INFORMANT'S NAME (Type/Print): Elma Goodman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1626 E. 30th St. Baltimore, Md. 21218
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Calvary Cemetery
20c. LOCATION — City or Town, State: Balto. Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Calvin B. Scruggs, Sr.
22. NAME AND ADDRESS OF FACILITY: Calvin B. Scruggs Funeral Home, 1412 E. Preston Street, Baltimore, Maryland 21213

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pancreatic carcinoma | Unknown |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Small bowel obstruction
Gastrointestinal bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: David Holt MD
29c. LICENSE NUMBER: AS402332 PH9462
29d. DATE SIGNED (Month, Day, Year): 11/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Holt, Johns Hopkins Hospital, Balt., Md 21205
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

89 29831

89 29835

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY SACKS
2. DATE OF DEATH: MONTH 10 DAY 31 YEAR 89
3. TIME OF DEATH: 12:18 a.m.
4. SOCIAL SECURITY NUMBER: 093-05-3963
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/26/1899
8. BIRTHPLACE (State or Foreign Country): ENGLAND
9a. FACILITY NAME (If not institution, give street and number): HEBREW HOME Of Greater Washington
9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: New Jersey
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Wildwood Crest
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 213 East Columbine Road
10f. ZIP CODE: 08260
10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 years — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Merchant - Owner
16b. KIND OF BUSINESS/INDUSTRY: Ladies Apparel

17. FATHER'S NAME (First, Middle, Last): Joseph Pliss
18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Goldberg

19a. INFORMANT'S NAME (Type/Print): Betty Fox Balsom
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 213 East Columbine Road, Wildwood Crest, N. J. 08260

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beth Kehillah Cemetery
20c. LOCATION — City or Town, State: Pleasantville, N. J.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein
22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME, 232 CARROLL STREET, N.W., WASHINGTON, D.C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara Carroll MD
29c. LICENSE NUMBER: D38392
29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARBARA CARROLL MD., 6105 MONTROSE RD

31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-10 Rev 1/89

89 29836

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

4

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALMA M. SNOW | | | 2. DATE OF DEATH (Month / Day / Year): 11 / 01 / 89 | 3. TIME OF DEATH: 4:20 P M |
| 4. SOCIAL SECURITY NUMBER: 218-38-4748 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 04/29/16 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): St Joseph Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH: Towson, MD 21204 | | 9c. COUNTY OF DEATH: BALTO |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Baltimore | Cockeysville | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 285 Byron Lane | 21030 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12): 8 | College (1-4 or 5+): | Nurses Aid | Nursing Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| William BOsley | Mary Elizabeth BUrrs |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Lorraine Sommer | Cockeysville, MD 21030 |

| 20a. METNOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Wiseburg Cemetery | White Hall, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Charles T. Bowen | J. J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hepatic Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cirhosis of the Liver
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Beatriz P. Dizon M.D. | 016492 | ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BEATRIZ P. DIZON St. Joseph Hospital Towson Md.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julie Davidson-Randall |

ONMH-16 Rev 1/89

89 29836

89 29837

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

15

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THEODOR STRAUS | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 31, 1989 | 3. TIME OF DEATH: 11:24 A. M |
| 4. SOCIAL SECURITY NUMBER: 059-30-4670 | 5. SEX: 1 XX M 2 ☐ F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): DEC. 28, 1919 / 8. BIRTHPLACE (State or Foreign Country): GERMANY |
| 9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING, | 9c. COUNTY OF DEATH: MONTGOMERY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: MONTGOMERY | 10c. CITY, TOWN OR LOCATION: SILVER SPRING | 10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 3511 NAPIER STREET | | 10f. ZIP CODE: 20906 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALES - SUPPLIES | 16b. KIND OF BUSINESS/INDUSTRY: MAINTENANCE | |
| 17. FATHER'S NAME (First, Middle, Last): SALI STRAUS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSA RINDSBURG | |
| 19a. INFORMANT'S NAME (Type/Print): DORON S. STRAUS | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17406 BUEHLER ROAD, OLNEY, MARYLAND 20832 | |
| 20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JUDEAN MEMORIAL GARDENS | 20c. LOCATION — City or Town, State: OLNEY, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein | | 22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEB. MEM. FUNERAL HOME 232 CARROLL ST., N.W., WASHINGTON, D. C. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio pulmonary Arrest — 45 mins

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal Failure
Large Para Sacral Decubitus

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination, and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Howard Mulstein MD | 29c. LICENSE NUMBER: D-20389 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 29838

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELSIE ALEXANDRA SAMBORSKI
2. DATE OF DEATH (Month, Day, Year): NOV 3 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-05-8882A
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10-10-1904
8. BIRTHPLACE (State or Foreign Country): Poland
9a. FACILITY NAME (If not institution, give street and number): 6 South Robinson St.
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6 South Robinson Street
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John Wierzbicki
18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine ?
19a. INFORMANT'S NAME (Type/Print): Joseph Samborski
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 S. Robinson St. Balto. Md. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gardens of Faith
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roland P. Hauck Jr.
22. NAME AND ADDRESS OF FACILITY: John A. Moran, Inc. 3000 E. Balto. St. Balto. 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ASCVD Arrythmia - Atrial F. Both
DUE TO (OR AS A CONSEQUENCE OF):
b. Type II Diabetes Mellitus
DUE TO (OR AS A CONSEQUENCE OF):
c. Hypertension
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year):
26b. TIME OF INJURY: M
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED:
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: D24276
29d. DATE SIGNED (Month, Day, Year): ▶ 11-3-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29839

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MILDRED SMITH | | | | | 2. DATE OF DEATH (Month, Day, Year): NOVEMBER 2, 1989 | 3. TIME OF DEATH: 6 A.M. | |
| 4. SOCIAL SECURITY NUMBER: 219-16-3566 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): FEB. 3,1925 | 8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA | |
| 9a. FACILITY NAME (If not institution, give street and number): 7502 LISBURNE RD. 21208 | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE | | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7502 LISBURNE RD. | 10f. ZIP CODE: 21208 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRIVATE DUTY REGISTERED NURSE | 16b. KIND OF BUSINESS/INDUSTRY: MEDICINE | |
| 17. FATHER'S NAME (First, Middle, Last): LOUIS ROSEN | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE CARLINER | |
| 19a. INFORMANT'S NAME (Type/Print): BERNARD SMITH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7502 LISBURNE RD. BALTO., MD 21208 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO | 20c. LOCATION — City or Town, State: BALTO., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellensue Levinson | | 22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | CARDIAC ARREST | 0 |
| DUE TO (OR AS A CONSEQUENCE OF): b. | IDIOPATHIC DILATED CARDIOMYOPATHY | 12 YEARS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NONE

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Abraham Genecin M.D. | 29c. LICENSE NUMBER: DO 1421 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/2/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABRAHAM GENECIN M.D. 611 PARK AVENUE, BALTIMORE, MD 21201 | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-10 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29840

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD JEROME SCHAPIRO
2. DATE OF DEATH (Month, Day, Year): OCTOBER 31, 1989
3. TIME OF DEATH: 10:20 AM M
4. SOCIAL SECURITY NUMBER: 216-20-4925
5. SEX: XX M 2 F
6. AGE (In yrs. last birthday): 61 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): FEB 10,1928
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 11 POMONA SOUTH,APT. A3 (21208)
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 11 POMONA SOUTH, APT. 3
10f. ZIP CODE: 21208
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): VICE PRESIDENT MARKETING
16b. KIND OF BUSINESS/INDUSTRY: CHEMICALS
17. FATHER'S NAME (First, Middle, Last): HARRY B. SCHAPIRO
18. MOTHER'S NAME (First, Middle, Maiden Surname): PEARL FRIEDBERG
19a. INFORMANT'S NAME (Type/Print): MRS. LOIS SCHAPIRO
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 POMONA SOUTH ,APT. 3 BALTO.,MD 21208
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHIZUK AMUNO
20c. LOCATION — City or Town, State: BALTIMORE.,MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ellenore Levinson
22. NAME AND ADDRESS OF FACILITY: SOL LEVINSON & BROS.,INC. 6010 REISTERSTOWN RD. BALTO.,MD 21215

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. METASTATIC RENAL CELL CARCINOMA — Approximate Interval: 2/1989
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mario A. Eisenberger MD
29c. LICENSE NUMBER: D2768
29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARIO A. EISENBERGER 22 SOUTH GREENE ST BALTIMORE MD 21201
31. DATE FILED (Month, Day, Year): 10 NOV 1989
32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

89 29841

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WALTER M. SCHMIDT | | | | | 2. DATE OF DEATH (Month, Day, Year): 11-03-89 | 3. TIME OF DEATH: 7:17 p M |
| 4. SOCIAL SECURITY NUMBER: 21605 7664 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 09-29-19 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | | 9c. COUNTY OF DEATH: |
| RESIDENCE OF DECEDENT | | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE COUNTY | | 10c. CITY, TOWN OR LOCATION: | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 719 ALDWORTH RD | | | 10f. ZIP CODE: 21222 | | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): STEEL WORKER | | | 16b. KIND OF BUSINESS/INDUSTRY: BETH. STEEL | |
| 17. FATHER'S NAME (First, Middle, Last): WALTER SCHMIDT | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): KATHERINE SIWIK | | |
| 19a. INFORMANT'S NAME (Type/Print): MS. BARBARA J. WILHELM | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 719 ALDWORTH ROAD BALTO. MD. 21222 | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OAKLAWN CEMETERY | | 20c. LOCATION — City or Town, State: BALTO. MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Raymond L. Kaczorowski | | | 22. NAME AND ADDRESS OF FACILITY: KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. 21224 | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS SEPSIS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

STROKE STROKE
SHORT BOWEL SYNDROME SHORT BOWEL SYNDROME
NEPHROTIC SYNDROME NEPHROTIC SYNDROME

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [illegible] MD | D15135 | ▶ 11/3/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PENELOPE P. SCOTT MD CHURCH HOSPITAL, BALTIMORE MD 21231

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | [illegible] Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29041

89 29842

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RICHARD Ernest SINDT | | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 30, 1989 | 3. TIME OF DEATH: 9:45 P M |
| 4. SOCIAL SECURITY NUMBER: 481-40-2715 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): Aug. 21, 1938 | 8. BIRTHPLACE (State or Foreign Country): Iowa |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baldwin | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 3112 Moores Road | | 10f. ZIP CODE: 21013 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+): 4 Years | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Data Processing Manager | 18b. KIND OF BUSINESS/INDUSTRY: Environmental Technology Group, Inc. | |
| 17. FATHER'S NAME (First, Middle, Last): Fred A. Sindt | | 16. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Conkety | |
| 19a. INFORMANT'S NAME (Type/Print): Judith A. Sindt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3112 Moores Rd. Baldwin, Md. 21013 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Highview Cemetery | 20c. LOCATION — City or Town, State: Fallston, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F. Burnside, Jr. James F. Burnside, Jr. | 22. NAME AND ADDRESS OF FACILITY: Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Lactic Acidosis c Resp/Cardiac Failure | 4 days |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Sepsis | 4 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. Lymphoma 2° to Renal Transplant | 6 mos |
| DUE TO (OR AS A CONSEQUENCE OF): | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [ ] YES 2 [X] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: David W. Allen MD Physician | 29c. LICENSE NUMBER: 29814 | 29d. DATE SIGNED (Month, Day, Year): 10/20/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID Allen, MD JHH Baltimore, MD | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Esther Davidson-Randall | |

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and Death Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

S/885 88

89 29843

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): GUSTAVE . TRIBULL JR | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 5.45 AM M |
| 4. SOCIAL SECURITY NUMBER: 578-32-8907 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-27-11 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Pasadena | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8876 Fort Smallwood Road | | 10f. ZIP CODE: 21122 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 years | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Estimator / Engineer | 16b. KIND OF BUSINESS/INDUSTRY: Baltimore Contractor |
| 17. FATHER'S NAME (First, Middle, Last): Gustave Tribull Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret P. Ditmayer | |
| 19a. INFORMANT'S NAME (Type/Print): Margaret Tribull | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8876 Fort Smallwood Road Pasadena, Maryland 21122 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Baltimore, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ C Richard Gonce | | 22. NAME AND ADDRESS OF FACILITY: Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Congestive Heart Failure | 10 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Chronic Renal Disease | 3 years |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | Acute Renal Failure | 3 weeks |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D20094 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ELLIOTT GORBATY, M.D. 7845 OAKWOOD ROAD, #203 GLEN BURNIE, MD 21061 | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

Unknown # 89-199

Items:23 thru 28f per ME G-658
12-12-89 cm

89 29844

4

8

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LINDA TALBOTT | | | 2. DATE OF DEATH (Month, Day, Year): 10 27 89 | 3. TIME OF DEATH: 11:52 A M |
| 4. SOCIAL SECURITY NUMBER: 215-78-8905 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 30 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7 30 59 | 8. BIRTHPLACE (State or Foreign Country): Wash., D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): 14900 Blk. Van Dusin Road(creek bed) | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: Prince George's |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Prince George's | 10c. CITY, TOWN OR LOCATION: Laurel | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 39 4th Street | | 10f. ZIP CODE: 20707 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: W. R. Grace Co. |
| 17. FATHER'S NAME (First, Middle, Last): Jack M. Pivowar | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Pauline M. White | |
| 19a. INFORMANT'S NAME (Type/Print): Jack M. Pivowar | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6507 Brooklyn Bridge Road | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): B'Nai Israel | 20c. LOCATION — City or Town, State: Oxon Hill, Md |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Eric P. Wandsworth | | 22. NAME AND ADDRESS OF FACILITY: Ives-Pearson Funeral Homes 2847 Wilson Blvd., Arlington, Va | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Drowning | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) (creek bed) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): UNKNOWN | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO | 28d. DESCRIBE HOW INJURY OCCURED: Subject drowned |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Creek Bed | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 14900 Van Dusin Road Laurel, P.G. County, Maryland |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank J. Peretti, M.D. - Assistant | 111 Penn St. | Balto.MD. |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 131, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29845

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Ailee Frances Taylor | | 2. DATE OF DEATH (Month, Day, Year): 10 / 01 / 89 | 3. TIME OF DEATH: 18:05 PM |
| 4. SOCIAL SECURITY NUMBER: 231-58-3590 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): October 10, 1918 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): WASHINGTON ADVENTIST Hosp | 9b. CITY, TOWN OR LOCATION OF DEATH: Takoma PK | 9c. COUNTY OF DEATH: Montgomery |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Virginia | 10b. COUNTY: Alleghany County | 10c. CITY, TOWN OR LOCATION: Covington | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: Route 2 | 10f. ZIP CODE: 24426 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel Byer | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Fridley | | |
| 19a. INFORMANT'S NAME (Type/Print): Ernest J. Taylor (Husband( | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2, Covington, Virginia 24426 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Humphries Cemetery | 20c. LOCATION — City or Town, State: Alleghany County, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE #M00690: ▶ Howard A. Carson | 22. NAME AND ADDRESS OF FACILITY: Arritt Funeral Home, 1102 South Highland Avenue, Covington, VA 24426 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter tha moda of dying, such aa cardiac or reapiratory arreat, shock, or haert failure. List only one cause on each lina.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest — DUE TO (OR AS A CONSEQUENCE OF): | 7.55 min |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cardiomyopathy — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary artery disease — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: ☒ 1 Natural ☐ 2 Accident ☐ 3 Suicide ☐ 4 Homicide ☐ 5 Pending Investigation ☐ 6 Could not be determined | 28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Fayez A. Shawl MD | 29c. LICENSE NUMBER: D 22639 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11/1/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Director, ~~Medicine~~ Interventional Cardiology, Washington Adventist Hospital, Takoma Park MD. 20912

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29045

89 29846

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Henry Milton VOLZ | | | 2. DATE OF DEATH (Month, Day, Year): November 2, 1989 | 3. TIME OF DEATH: 4:18 PM |
| 4. SOCIAL SECURITY NUMBER: 213-12-2169 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 4-18-09 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Rossville | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: 8770 Philadelphia Rd. Rossville | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 8770 Philadelphia Rd. | | 10f. ZIP CODE: 21237 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Farmer | 16b. KIND OF BUSINESS/INDUSTRY: Self-Employed | |
| 17. FATHER'S NAME (First, Middle, Last): John C. Volz | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Amelia H. R. Schaub | |
| 19a. INFORMANT'S NAME (Type/Print): H. Lorraine Volz | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8770 Philadelphia Rd. Balto., Md. 21237 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Zion Church Cemetery | 20c. LOCATION — City or Town, State: Baltimore, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Rossville Funeral Home | 22. NAME AND ADDRESS OF FACILITY: 7401 Belair Rd. Baltimore, Maryland 21236 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary Edema. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Acute myocardial infarction. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Cardiac Arrythmia. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

metastatic colon carcinoma.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jonathan Seidenberg M.D. | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jonathan Seidenberg, M.D. 9000 Franklin Square Dr., Balto., 21237

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

OHMH-16 Rev 1/89

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89 29847

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| LUCY | WYATT | 10 31 89 | 5:50 (AM) |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 246 24-0344 | 1 ☐ M 2 ☒ F | 73 YRS. | | | 7-23-16 | |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Seton Manor Nursing Home | Baltimore | MD |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | | Baltimore City | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 501 W Franklin | 21201 | U.S |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO Specify: | Specify: |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | | | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| | |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Seton Hill Manor Record | 501 W Franklin ST |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Mt. Zion | Balto. Co |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ | Flevin Carroll Funeral Home 1712 N. Northern |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. – Probable Cerebro Vascular Accident. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Generalized Arteriosclerosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

– Pancytopenia
– Diabetes.
– Seizures.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CASE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | | | | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| L Ruder M.D. | D-22609 | ▶ 11-2-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

RUBEN REIDER M.D 7445 FURNACE BRANCH Rd Glen Burnie Md 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2987

89 29848

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): NELLIE WRIGHTSON Nellie Irene Wrightson | | | 2. DATE OF DEATH: MONTH 11 DAY 3 YEAR 89 | 3. TIME OF DEATH: 4:22 A M |
| 4. SOCIAL SECURITY NUMBER: 215-18-5941 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6-17-20 |
| 8. BIRTHPLACE (State or Foreign Country): Md. | | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: ---------- | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 6519 DANVILLE AVE. | 10f. ZIP CODE: 21224 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: W.W.2 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): Adolph H.E. Teichert | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie I. Shipley | | |
| 19a. INFORMANT'S NAME (Type/Print): Edward Wrightson | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6519 Danville Ave. Balto., Md. 21224 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Mount Crematorium | 20c. LOCATION — City or Town, State: Balto. City, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Charles S. Zeiler | 22. NAME AND ADDRESS OF FACILITY: Charles S. Zeiler & Son Inc. 6224 Eastern Ave. | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest | CARDIAC ARREST | 1 ~~1~~ HR. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b. Aortic stenosis | AORTIC STENOSIS | 10 yrs YRS |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ~~NO~~ | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES ☒ ~~NO~~ |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Christopher Hogan M.D | 29c. LICENSE NUMBER: D32344 | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-3-89 ~~11-3789~~ 11/3/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): 100 N. BROADWAY BALTIMORE, MD. 21231 ~~110 N. BROADWAY BALTIMORE MD~~ | DR. CHRISTOPHER HOGAN, M.D. | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: Gloria Anderson-Randall | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29848

89 29849

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jeanette S Williams | | 2. DATE OF DEATH (Month, Day, Year): 11-4-89 | 3. TIME OF DEATH: 4:09PM M |
| 4. SOCIAL SECURITY NUMBER: 219-18-2910 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10-27-24 |
| 8. BIRTHPLACE (State or Foreign Country): Gaithersburg Md. | | | |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 2026 Old Frederick Rd. Baltimore, Md. | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): William Earl Steigleman | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Margaret Smith | | |
| 19a. INFORMANT'S NAME (Type/Print): Horace H. Williams | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2026 Old Frederick Rd. Balto, Md. 21228 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory | 20c. LOCATION — City or Town, State: Silver Spring Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Roland P. Stahl | 22. NAME AND ADDRESS OF FACILITY: Sterling Ashton Funeral Home, P.A. 736 Edmondson Ave. Balto Md. 21228 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): ▶ 11-5-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ann M. Dixon, MD 111 PENN Street, Baltimore, MD 21201 VC | | |
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: | |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29849

89 29850

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JESSIE E. WELLIS | | 2. DATE OF DEATH (Month - Day - Year): 10 - 31 - 89 | 3. TIME OF DEATH: 7:50 A M |
| 4. SOCIAL SECURITY NUMBER: 146-12-2467 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-22-17 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: MD. MD. | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: BALTIMORE CITY | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7232 GERMAN HILL RD. HERITAGE NURS HOME | | 10f. ZIP CODE: 21222 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced XX | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO X — IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): O.R.TECHNICIAN | 16b. KIND OF BUSINESS/INDUSTRY: HOSPITAL | |
| 17. FATHER'S NAME (First, Middle, Last): ELMER POWLESS | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): DAISY PARTINGTON | |
| 19a. INFORMANT'S NAME (Type/Print): MARY JANE EBAUGH | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7829 CHARLESMONT RD. DUNDALK, MD. 21222 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDEN PARK CEMETERY | 20c. LOCATION — City or Town, State: BALTO., MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Walter B. Bradley | | 22. NAME AND ADDRESS OF FACILITY: WALTER B. BRADLEY F. HOME, INC. 2134 WILLOW SPRING RD. DUNDAK, MD. 21222 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. R/ MYOCARDIAL INFARCTION | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. ASCVD. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): NONE — 28b. TIME OF INJURY: M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: George Thomas | 29c. LICENSE NUMBER: D18977 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ~~GEORGE THOMAS M.D.~~ GEORGE THOMAS M.D. % CHURCH HOSP CORP 100 N. BROADWAY, BALTIMORE, MD 21231

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): NOV 6 1989 | 32. REGISTRAR'S SIGNATURE: |

DHMH-16 Rev 1/89

89 29820

89 29851

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIE WARD. | | 2. DATE OF DEATH (Month / Day / Year): 10 / 31 / 89 | 3. TIME OF DEATH: 1230 AM |
| 4. SOCIAL SECURITY NUMBER: 237-30-2285 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 3/4/1916 |
| 8. BIRTHPLACE (State or Foreign Country): North Carolina Speights Bridge | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Washington Adventist | 9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Pk, Md | 9c. COUNTY OF DEATH: MONT. | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: DC | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Washington, DC | 10d. INSIDE CITY LIMITS? XX [X] YES 2 [ ] NO |
| 10a. STREET AND NUMBER: 131 U Street NE | | 10f. ZIP CODE: 20002 | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed XX [X] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? XX [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES XXXX [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th Grade; College (1-4 or 5+): None | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): =Govt Worker | 16b. KIND OF BUSINESS/INDUSTRY: US Govt | |
| 17. FATHER'S NAME (First, Middle, Last): Lawrence Ward | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Cornelia Bullock | | |
| 19a. INFORMANT'S NAME (Type/Print): Anna Creech (Sister) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a,b,c,d,e &f | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft Lincoln | 20c. LOCATION — City or Town, State: Brentwood, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Murphy & Robinson 180 | 22. NAME AND ADDRESS OF FACILITY: John T Rhines Co 3015 12th Street NE, DC 20017 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. METASTATIC COLON CANCER | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| ATTENDING | D31124 | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS A. TESORIERO 1011 NO. CAPITOL NE, WASHDC 20002

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| 10/31/NOV 6 1989 | Gloria Davidson-Randall |

DHMH-16 Rev 1/89

89 29851

89 29852

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Henry Warren
2. DATE OF DEATH — MONTH: 10 DAY: 28 YEAR: 89
3. TIME OF DEATH: 1:27 P M
4. SOCIAL SECURITY NUMBER: 215-18-3805
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-15-17
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): UNIVERSITY OF MD. HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

**RESIDENCE OF DECEDENT**

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 501 W. FRANKLIN ST.
10f. ZIP CODE: 21201
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY: Moving Co.
17. FATHER'S NAME (First, Middle, Last): Henery Spriggs
18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Spriggs
19a. INFORMANT'S NAME (Type/Print): Karen Dunsen (daughter)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1017 McAleer ct. 21202
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion
20c. LOCATION — City or Town, State: Baltimore
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William Parson
22. NAME AND ADDRESS OF FACILITY: Carolina Funeral Ser. 4511 Pen Lucy rd. STATE ANATOMY BOARD, BALTO., MD. 21201

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Dilated Cardiomyopathy
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jonathan B. Owens MD
29c. LICENSE NUMBER: D37570
29d. DATE SIGNED (Month, Day, Year): 10-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jonathan B. Owens MD 22 S. Greene St Baltimore
31. DATE FILED (Month, Day, Year): NOV 6 1989
32. REGISTRAR'S SIGNATURE:

OHMH-16 Rev 1/89

89 29853

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Olive A. Zengel | | | | 2. DATE OF DEATH (Month, Day, Year): 10 31 89 | 3. TIME OF DEATH: 2:30 PM |
| 4. SOCIAL SECURITY NUMBER: 215-24-5787 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3/8/96 | 8. BIRTHPLACE (State or Foreign Country): Baltimore Cty |
| 9a. FACILITY NAME (If not institution, give street and number): Berlin Nursing Home | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Berlin | | 9c. COUNTY OF DEATH: Worcester |
| **RESIDENCE OF DECEDENT** | | | | | |
| 10a. STATE: MARYLAND | 10b. COUNTY: BALTIMORE | 10c. CITY, TOWN OR LOCATION: DUNDALK | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1636 MANOR ROAD | | 10f. ZIP CODE: 21222 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4 or 5+): N/A | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CASHIER | | 16b. KIND OF BUSINESS/INDUSTRY: GRAND THEATRE | |
| 17. FATHER'S NAME (First, Middle, Last): GEORGE CANOLES | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA BROOKS | |
| 19a. INFORMANT'S NAME (Type/Print): JOSEPH E. ZENGEL | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1617 SEARLES ROAD BALTIMORE, MARYLAND 21222 | | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARDENS OF FAITH CEM. 11-3-89 | | 20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Charles W. Fahl | | 22. NAME AND ADDRESS OF FACILITY: DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK,MD 21222 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive Heart Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Albert Dacanay | D29987 | ▶ 10/31/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Albert Dacanay, M.D. 309 Timmons St., Snow Hill, MD 21863

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| NOV 6 1989 | Gloria Davidson Randall |

DHMH-16 Rev 1/89

89 29854

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): GLADYS IRENE ALTON | | | | | 2. DATE OF DEATH (Month, Day, Year): 10-29-89 | 3. TIME OF DEATH: 7:15P M |
| 4. SOCIAL SECURITY NUMBER: 278227118 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-16-1919 | 8. BIRTHPLACE (State or Foreign Country): OH |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | | 9c. COUNTY OF DEATH: ALLEGANY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Allegany | Cumberland | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 535 Haddon Avenue | 21502 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12): 11 | College (1-4 or 5+): | housewife | own home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Boyd | Mae Porter |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Audrey Bigler | 535 Haddon Avenue, Cumberland, MD 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | Fort Steuben Burial Estates | Wintersville, OH |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James J Scarpelli | Scarpelli Funeral Home, Cumberland, MD 21502 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic adenocarcinoma of | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): ovarian neoplasm. | 2-3 years |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Carcinomatosis, diffuse of abdomen | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John J Mehanna MD | D-17526 | ▶ 10-30-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR J MEHANNA 909 B SETON DR CUMBERLAND, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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89 2902F

89 29855

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NADINE M ANTHONY
2. DATE OF DEATH (Month, Day, Year): 10-27-89
3. TIME OF DEATH: 12:25AM M
4. SOCIAL SECURITY NUMBER: 214071677
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7-26-1908
8. BIRTHPLACE (State or Foreign Country): W.Va.
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Frostburg
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 100 Honeysuckle Lane Apt. 412
10f. ZIP CODE: 21532
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: X
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Textile
17. FATHER'S NAME (First, Middle, Last): Unknown - Matthews
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): Cleo Orlando
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 496 Grandview, Hubbard, Ohio 44425
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park
20c. LOCATION — City or Town, State: Frostburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John P. Horn
22. NAME AND ADDRESS OF FACILITY: Durst Funeral Home, Frostburg, Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. POORLY DIFFERENTIATED CARCINOMA OF THE RIGHT LUNG
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: METASTASIS TO THE BRAIN, LIVER & BONE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: S. Chang M.D.
29c. LICENSE NUMBER: D25638
29d. DATE SIGNED (Month, Day, Year): ▶ 10/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FROSTBURG PLAZA FROSTBURG MD 21532 SATURNINA. CHANG M.D.
31. DATE FILED (Month, Day, Year): OCT 30 1989
32. REGISTRAR'S SIGNATURE: Lisha Davidson-Randall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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OHMH-18 Rev 1/89

89 29856

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): JOHN ANDREW BENDER | | | | | 2. DATE OF DEATH MONTH 10-25 DAY 89 YEAR | | 3. TIME OF DEATH 3:15PM M |
| 4. SOCIAL SECURITY NUMBER: 220267621 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 09-18-1923 | | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND | | | 9c. COUNTY OF DEATH: ALLEGANY | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Allegany | | 10c. CITY, TOWN OR LOCATION: Cumberland | | | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO | |
| 10a. STREET AND NUMBER: 448 Walnut Street | | | | 10f. ZIP CODE: 21502 | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: white | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired back shops | | | 16b. KIND OF BUSINESS/INDUSTRY: railroad | |
| 17. FATHER'S NAME (First, Middle, Last): Alpheus F. Bender | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Mulligan | | | |
| 19a. INFORMANT'S NAME (Type/Print): Filomena Bender | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 448 Walnut Street, Cumberland, MD 21502 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park | | | 20c. LOCATION — City or Town, State: Cumberland, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Carcinoma, metastatic to Brain

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease;
Colon Carcinoma.

| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |
|---|---|

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |
|---|---|

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Thomas E. Chappell MD | MD 35755 | ▶ 10/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas E. Chappell MD 912 Seton Dr. Cumberland MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 26 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 through 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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89 29857

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| Dorothy Virginia Close | | Oct. 18, 1989 | 12:30 P.M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-05-4247 | 1 ☐ M 2 ☒ F | 78 YRS. | | | 2-15-1911 | Md. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Frostburg Nursing Home | Frostburg | Allegany |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Md. | Allegany | Frostburg | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 325 E. Main St. | 21532 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 2 | Teacher | Nursery School |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Allen Stewart | Elsie Lewis |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Karen Delaney | 75 Frost Ave., Frostburg, Md. 21532 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Eckhart Cemetery | Eckhart, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ John P. Horn | Durst Funeral Home, Frostburg, Md. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIO RESPIRATORY FAILURE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ACUTE MYOCARDIAL INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ORGANIC BRAIN SYNDROME
DIABETES MELLITUS.
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| S. Chang M.D. | D25638 | ▶ 10/19/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

S.T. Chang, M.D., Frostburg Plaza, Frostburg, Md. 21532

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 20 1989 | Gisha Davidson-Kendall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 29858

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| HAROLD | JAMES | DREYER | OCTOBER 23, 1989 | 7:18 A. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 705-05-4815 | 1 [X] M 2 [ ] F | 89 YRS. | | | NOV. 6 1899 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 819 MAPLEWOOD LANE | 21502 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | BALTIMORE & OHIO RAILROAD | MACHINIST |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| FREDERICK DREYER | MARGARET REYNOLDS |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| BONNIE McGOLERICK | 4416 TREGO ROAD, KEEDYSVILLE, MARYLAND 21756 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | SUNSET MEMORIAL PARK | CUMBERLAND MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Dale L. Merritt | SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Nc Respiratory Failure | 1day |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Probable Aspiration Pneumonia | 1day |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | D33282 | ▶ 10/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Sunil K. Gupta 69 Greene St. Cumberland, MD. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 23 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

88 50828

89 29859

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LLOYD WILSON EYRE | | | | | 2. DATE OF DEATH: MONTH 10 DAY 27 YEAR 89 | | 3. TIME OF DEATH: 1:56PM M |
| 4. SOCIAL SECURITY NUMBER: 214070997 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 05-08-1913 | | 8. BIRTHPLACE (State or Foreign Country): WV |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: WV | 10b. COUNTY: Mineral | | 10c. CITY, TOWN OR LOCATION: Wiley Ford | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | | |
| 10e. STREET AND NUMBER: P.O. Box 29 | | | 10f. ZIP CODE: 26767 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: white | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): engineer | | 16b. KIND OF BUSINESS/INDUSTRY: railroad | | |
| 17. FATHER'S NAME (First, Middle, Last): Clarence Addison Eyre | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Zetta Lucille McFadden | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Mary G. Eyre | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 29, Wiley Ford, WV 26767 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Burial Park | | 20c. LOCATION — City or Town, State: Cumberland, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli | | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Gastrointestinal Bleeding | 36hrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Chronic Myelocytic Leukemia | 10 mo. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Thrombocytopenia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul Livengood MD | 29c. LICENSE NUMBER: D23774 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/30/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR P LIVENGOOD 912 SETON DR CUMBERLAND, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

7

89 29860

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| MARY | TERESA | GORDON | October 28, 1989 | 2:00 P. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 705-05-8004 | 1 ☐ M 2 ☒ F | 84 YRS. | | | 03-30-1905 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital & Medical Center | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Allegany | Cumberland | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 19 South Street | 21502 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | housewife | own home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Edward C. Mackert | Agnes Logsdon |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Mary Ann Welsh | Cumberland, MD 21502 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Sunset Memorial Park | Cumberland, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James F Scarpelli | Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive heart failure | 3 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Ischemic cardiomyopathy | years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William D Lamm MD | D25406 | ▶ 10-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. William D. Lamm, 47 Virginia Avenue, Cumberland, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 30 1989 | Gina Davidson-Randall |

DNMH-16 Rev 1/89

3

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29860

89 29861

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Victoria VALETTA V. GROSS
2. DATE OF DEATH (Month, Day, Year): October 30, 1989
3. TIME OF DEATH: 7:40 A. M
4. SOCIAL SECURITY NUMBER: 212-38-5531
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)
7. DATE OF BIRTH (Month, Day, Year): FEB 20 1908
8. BIRTHPLACE (State or Foreign Country): INDIANA
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital & Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ALLEGANY
10c. CITY, TOWN OR LOCATION: LAVALE
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9 ASBURY AVENUE
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: usa
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SCHOOL TEACHER
16b. KIND OF BUSINESS/INDUSTRY: SCHOOL TEACHER
17. FATHER'S NAME (First, Middle, Last): FRED GARFIELD CHAMBERLAIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): LYDIA MAY CRONK
19a. INFORMANT'S NAME (Type/Print): JOHN ROBERT GROSS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9 ASBURY AVE LAVALE, MARYLAND 21502
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): State of Md. Anatomical Board
20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dale L. Merritt
22. NAME AND ADDRESS OF FACILITY: SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND, MARYLAND

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cerebrovascular Accident, Probable | 2 hs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Arteriosclerosis | yrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: A-V malformation bowel & G I bleeding

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John T. Whitmore MD
29c. LICENSE NUMBER: D 19229
29d. DATE SIGNED (Month, Day, Year): ▶ 10-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Whitmore , P.O. Box 3675, LaVale, MD 21502
31. DATE FILED (Month, Day, Year): OCT 31 1989
32. REGISTRAR'S SIGNATURE: Jacha Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

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89 29862

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| CLETUS WINIFRED ISER | | 10-27-1989 | 12:30 AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 232-74-4577 | 1 ☐ M 2 ☒ F | 84 YRS. | | | April 7,1905 | WEst Virginia |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| SACRED HEART HOSPITAL | Cumberland | ALLEGANY COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| WV | Hampshire | Romney | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 425 North High Street | 26757 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| N/A | | Homemaker | Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Thomas Mulledy Sr. | Agnes Barnes |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Olive Irene Everett | Rt. 1, Box 146, Romney, WV 26757 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Branch Mt. Cemetery | Three Churches, WV |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Sarah S. Morgret | Shaffer Funeral Home, Inc. 230 East Main Street, Romney, WV 26757 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reepiratory arreat, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Finel disease or condition resulting in death) →
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Rheumatoid Arthritis, Coastrointestinal Bleeding, Urinary tract infection, Aspiration pneumonia, Decubitus ulcers

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D 35135 | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BMG Thomas E. Chappell MD 912 Seton Dr. Cumberland MD.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 31 1989 | Gina Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 2982

89 29863

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| DORIS | GRAY | JEWELL | October 25, 1989 | 9:25 a M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 249-32-6442 | 1 ☐ M 2 ☒ F | 63 YRS. | | | 01-21-1926 | SC |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Allegany | Oldtown | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Route 1 Box 432 | 21555 | USA |

| 11. MARITAL STATUS | 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. OECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | housewife | own home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Charlie Blakley | Alice Owens |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Robert L. Jewell | Route 1 Box 432, Oldtown, MD 21555 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Rocky Gap Veterans Cemetery | Flintstone, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James F. Scarpelli | Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Acute MI and CAD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c. Acute Ischemic Bowel Ileus
DUE TO (OR AS A CONSEQUENCE OF):
d. Occlusion Artery Disease

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Terry Williams MD | D16041 | ▶ 10-26-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Terry Williams, Memorial Hospital Medical Building, Cumberland, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 27 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

89 29864

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| LORETTA | LILLIAN | LANTZ | 10-17-89 | 12:07 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 498-18-0152 | 1 ☐ M 2 ☒ F | 64 YRS. | | | 11-03-1924 | MO |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| MEMORIAL HOSPITAL | CUMBERLAND | ALLEGANY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| WV | Mineral | Wiley Ford | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| P.O. Box 152 (Clearview Avenue) | 26767 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | housewife | own home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John Hoelker | Minnie Freedman |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Miss Constance Lantz | P.O. Box 152, Wiley Ford, WV 26767 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Restlawn Memorial Gardens | LaVale, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James F. Scarpelli | Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MULTIPLE INJURIES COMPLICATING HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☒ YES 2 ☐ NO | 1 ☒ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 10/17/89 | 11:30AM | 1 ☐ YES 2 ☒ NO | DRIVER IN AUTO LOST CONTROL |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| ROAD | RT. 220 & MILNOR AVE BOWLING GREEN, ALLEGANY CO. MD |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 10-18-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James Kaplan, M.D. - Assistant 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 24 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

6

89 SEP 28

89 29865

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN BRYD LESTER
2. DATE OF DEATH (Month, Day, Year): 10/26/1989
3. TIME OF DEATH: 2:35 am M
4. SOCIAL SECURITY NUMBER: 217287617
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): MAY 28 1912
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND
9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ALLEGANY
10c. CITY, TOWN OR LOCATION: CUMBERLAND
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 208 POLK STREET
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY: HOUSEWIFE
17. FATHER'S NAME (First, Middle, Last): LORENZO RICE
18. MOTHER'S NAME (First, Middle, Maiden Surname): MATILDA JOHNSTON
19a. INFORMANT'S NAME (Type/Print): LOIS J. SCHADT
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 533 FURNACE STREET CUMBERLAND MARYLAND 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): REST LAWN MEMORIAL PARK
20c. LOCATION — City or Town, State: LAVALE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dale L. Merritt
22. NAME AND ADDRESS OF FACILITY: SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Respiratory failure | 2 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Bilateral Pneumonia | 1 week |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D33280
29d. DATE SIGNED (Month, Day, Year): 10/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SUNIL GUPTA, M.D. 69 Greene Street, Cumberland, MD 21502
31. DATE FILED (Month, Day, Year): OCT 27 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29866

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET Davis MALONE | | | | | 2. DATE OF DEATH (Month, Day, Year): October 18, 1989 | 3. TIME OF DEATH: 4:40 p M | |
| 4. SOCIAL SECURITY NUMBER: 219-14-6442 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 3-11-1918 | 8. BIRTHPLACE (State or Foreign Country): West Virginia | |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Cumberland | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | | |
| 10e. STREET AND NUMBER: Booth Towers-220 Somerville Ave. | | 10f. ZIP CODE: 21502 | | | 10g. CITIZEN OF WHAT COUNTRY?: USA | | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | | 16b. KIND OF BUSINESS/INDUSTRY: Home | | |
| 17. FATHER'S NAME (First, Middle, Last): George H. Davis | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Keplinger | | |
| 19a. INFORMANT'S NAME (Type/Print): Carolyn Davis | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box-188 Cumberland, Md. 21502 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park | | | 20c. LOCATION — City or Town, State: Cumberland, Md. 21502 | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ernest A. Riley, Jr. | | | | | 22. NAME AND ADDRESS OF FACILITY: Leasure-Stein, Inc. 21502 230 Baltimore Av. Cumberland, Md/ | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):
b. Congestive Heart failure

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. ventricular tachycardia

DUE TO (OR AS A CONSEQUENCE OF):
d. Severe Coronary Artery Disease

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Lung Cancer
w/ Metastasis from Lung Ca

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: D 36766

29d. DATE SIGNED (Month, Day, Year): ▶ 10-19-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Poonai 719 Williams Street, Cumberland, MD 21502

31. DATE FILED (Month, Day, Year): OCT 20 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

3

89 29866

89 29867

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| JOSEPH | JOHN | MAZUREK | OCTOBER 26, 1989 | 1:30P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 194-16-3138 | 1 [X] M 2 [ ] F | 64 YRS. | | | 12-25-24 | PENNSYLVANIA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| PA | MERCER | HERMITAGE | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1190 ORANGEVILLE ROAD | 16148 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES W.W.II | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 6+) | | |
| 12 | | SELF-EMPLOYED | JANITORIAL SERVICES |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| MIKE MAZUREK | STELLA BOYNICK |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| ETTA MAZUREK | 1190 ORANGEVILLE ROAD, HERMITAGE, PA 16148 |

| 20a. METNOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) | Lake Park Crematory | Youngstown, Ohio |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Hendy D. Upchurch | George-Upchurch Funeral Home, P.A. 202 Greene St., Cumberland, MD 21502 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Ventricular fibrillation

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Acute myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| [X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Halmos MD. | D04981 | ▶ 10/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. Peter Halmos Memorial Hospital Cumberland, Md. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 27 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

15

89 29868

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Anthony Thomas McElfish

**2. DATE OF DEATH** (Month, Day, Year): 10 19 1989

**3. TIME OF DEATH**: 9:45 AM

**4. SOCIAL SECURITY NUMBER**: 220-10-1663

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 79 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 03-06-1910

**8. BIRTHPLACE** (State or Foreign Country): PA

**9a. FACILITY NAME** (If not institution, give street and number): 447 N. Mechanic Street

**9b. CITY, TOWN OR LOCATION OF DEATH**: Cumberland

**9c. COUNTY OF DEATH**: Allegany

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: Allegany

**10c. CITY, TOWN OR LOCATION**: Cumberland

**10d. INSIDE CITY LIMITS?** 1 [X] YES 2 [ ] NO

**10e. STREET AND NUMBER**: 447 N. Mechanic Street

**10f. ZIP CODE**: 21502

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

**14. RACE — American Indian, Black, White, etc.**
Specify: white

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): engineering dept.

**16b. KIND OF BUSINESS/INDUSTRY**: textile

**17. FATHER'S NAME** (First, Middle, Last): William McElfish

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Eva Hollenberger

**19a. INFORMANT'S NAME** (Type/Print): Elizabeth A. McElfish

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 447 N. Mechanic Street, Cumberland, MD 21502

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Seven Dollars Cemetery

**20c. LOCATION — City or Town, State**: Clearville, PA

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ James F. Scarpelli

**22. NAME AND ADDRESS OF FACILITY**: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. A.S.C.V.D.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. _____ DUE TO (OR AS A CONSEQUENCE OF):

c. _____ DUE TO (OR AS A CONSEQUENCE OF):

d. _____

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [X] YES 2 [ ] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Francisco Reyes

**29c. LICENSE NUMBER**: D19316

**29d. DATE SIGNED** (Month, Day, Year): ▶ 10/19/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Francisco Reyes 900 Seton Dr. Cumberland, Md. 21502.

**31. DATE FILED** (Month, Day, Year): OCT 20 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

12

OHMH-16 Rev 1/89

89 29866

89 29869

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| AMBROSE EDWARD MICHAELS | | 10--26--1989 | 4:18 P.M. M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214070893 | 1 [X] M 2 [ ] F | 81 YRS. | | | 12/07/07 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| SACRED HEART HOSPITAL | CUMBERLAND | ALLEGANY COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| PA | BEDFORD | HYNDMAN | 1 [ ] YES 2 [XX] NO |

| 10a. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| R D 1, BOX 26A | 15545 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | LABORER | TIRE MANUFACTURING |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JOSEPH MICHAELS | ANN MARTIN |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DOLORES L. TWIGG | R D 1, BOX 26A, HYNDMAN, PA 15545 |

| 20a. METNOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | PALO ALTO HILLTOP CEMETERY | RD, HYNDMAN, PA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Harvey H. Zeigler | HARVEY H. ZEIGLER FUNERAL HOME CLARENCE ST., HYNDMAN, PA 15545 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS | 72 HRS. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. ACUTE CHOLECYSTITIS | 1 WK. |
| | DUE TO (OR AS A CONSEQUENCE OF): c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| M. Nallin MD | M 26770 | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

EUGENE NALLIN, M.D. P.O. BOX 606, HYNDMAN, PA 15545

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 30 1989 | Julia Davidson-Randall |

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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89 29870

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| WARREN | C. | MILLER | October 20, 1989 | 5:30 A.M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 553-03-5220 | 1 [X] M 2 [ ] F | 78 YRS. | | | 10-07-1911 | PA |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| PA | Bedford | Hyndman | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| R.D. 1 Box 293 | 15545 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO 10-15-1929-11-20-1930 | 1 [ ] YES 2 [X] NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | retired carpenter | carpentry |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James Jacob Miller | Katherine Brantano |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Elizabeth Corley | Box 254 Corriganville, MD 21524 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | IOOF Cemetery | Rockwood, PA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James F Scarpelli | Scarpelli Funeral Home Cumberland, MD 21502 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Arrest | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): Pulmonary Emb (DVT) | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): Parkinsons + chronic ulcer disease | |
| | d. DUE TO (OR AS A CONSEQUENCE OF): ASCVD | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William Lamm for Dr Lamm | D25406 | ▶ 10-27-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. William Lamm, 47 Virginia Avenue, Cumberland, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 23 1989 | |

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

5

89 29871

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALBERT HERBERT MORGAN SR.

2. DATE OF DEATH (Month, Day, Year): 10- 25 89

3. TIME OF DEATH: 03:00am M

4. SOCIAL SECURITY NUMBER: 214-05-4549

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)

7. DATE OF BIRTH (Month, Day, Year): 01-19-1900

8. BIRTHPLACE (State or Foreign Country): PA

9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland

9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Allegany

10c. CITY, TOWN OR LOCATION: LaVale

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 928 National Highway

10f. ZIP CODE: 21502

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): driver/salesman

16b. KIND OF BUSINESS/INDUSTRY: dairy

17. FATHER'S NAME (First, Middle, Last): Herbert Scott Morgan

18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Barnes

19a. INFORMANT'S NAME (Type/Print): Ada R. Morgan

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 928 National Hwy., LaVale, MD 21502

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunset Memorial Park

20c. LOCATION — City or Town, State: Cumberland, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F Scarpelli

22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic Congestive Heart Failure
Diabetes, occlusive disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: W. Hijab, MD

29c. LICENSE NUMBER: D11925

29d. DATE SIGNED (Month, Day, Year): ▶ 10/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. W. HIJAB 909-A SETON DR. CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year): OCT 26 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

4

89 29872

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| LILLIAN | MARGARET | REINHART | October 25, 1989 | 9:20 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 214-05-8274 | 1 ☐ M 2 ☒ F | 83 YRS. | | | 04-29-1906 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Allegany | Cumberland | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 825 Mt. Royal Avenue | 21502 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | buyer | dress shop |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| George L. Couter | Lucy Anna Martin |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Eleanor K. Dicken | Valley Road, Cumberland, MD |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Rosedale Funeral Chapel | Martinsburg, WV |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James F Scarpelli | Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Carcinoma of the breast with metastasis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. to the lungs | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atelectasis, Right lower lobe

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Robertrama J. Barrera MD | D 14865 | ▶ 10-26-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr. Barrera Memorial Hospital Medical Building, Cumberland, Md. 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 27 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

12

89 29873

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ESTELLA JANE SAVILLE | | | | 2. DATE OF DEATH (Month, Day, Year): 10 19 89 | 3. TIME OF DEATH: 05:50am M |
| 4. SOCIAL SECURITY NUMBER: 220-28-9471 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-13-1905 | 8. BIRTHPLACE (State or Foreign Country): WV |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Rawlings | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: P.O. Box 8 | | 10f. ZIP CODE: 21557 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housekeeping supervisor | 16b. KIND OF BUSINESS/INDUSTRY: hospital | |
| 17. FATHER'S NAME (First, Middle, Last): Samuel H. Funk | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah J. Hahn | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Ilda R. Lewis | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 8, Rawlings, MD 21557 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Asbury Cemetery | 20c. LOCATION — City or Town, State: Moorefield, WV |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James T Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, Cumberland, MD 21502 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdisc or respiratory srrest, shock, or heert feilure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Acute Myocardial Infarction | |
| DUE TO (OR AS A CONSEQUENCE OF): b. | Severe Coronary Artery disease | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D22181 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-20-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GARY WAGONER 925 BISHOP WALSH DR. CUMBERLAND, MD. 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall |

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

4

89 29874

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM LEE SCHAIDT | | | | | 2. DATE OF DEATH (Month, Day, Year): October 20, 1989 | 3. TIME OF DEATH: 3:00 A.M |
| 4. SOCIAL SECURITY NUMBER: 705-10-5924 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 10-09-1908 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: Allegany | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Allegany | 10c. CITY, TOWN OR LOCATION: Oldtown | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: P.O. Box 81 | | 10f. ZIP CODE: 21555 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): trackman | 16b. KIND OF BUSINESS/INDUSTRY: railroad | |
| 17. FATHER'S NAME (First, Middle, Last): John Schaidt | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clarabelle Flushenburg | |
| 19a. INFORMANT'S NAME (Type/Print): Alice Ruth Schaidt | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 81, Oldtown, MD 21555 | |
| 20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oldtown Cemetery | 20c. LOCATION — City or Town, State: Oldtown, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James F Scarpelli | | 22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerosis Anemia | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Senility | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Carcinoma of the Larynx | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. ASHD | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: William Lamm | 29c. LICENSE NUMBER: D25406 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-21-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. William Lamm, 47 Virginia Avenue, Cumberland, MD 21502

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12

DHMH-18 Rev 1/89

89 29875

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): AGNES IRENE STANSBERRY
2. DATE OF DEATH: MONTH 10 DAY 26 YEAR 89
3. TIME OF DEATH: 6:03 A M
4. SOCIAL SECURITY NUMBER: 214286458
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 59 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 07-07-1930
8. BIRTHPLACE (State or Foreign Country): ALLEGANY Co MD
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland
9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Allegany
10c. CITY, TOWN OR LOCATION: Cumberland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 10 E. Clement Street
10f. ZIP CODE: 21502
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housekeeping dept.
16b. KIND OF BUSINESS/INDUSTRY: hospital
17. FATHER'S NAME (First, Middle, Last): Daniel Parrish
18. MOTHER'S NAME (First, Middle, Maiden Surname): Agnes Glos
19a. INFORMANT'S NAME (Type/Print): Mrs. Madeline C. Harper
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 129 W. Second Street, Cumberland, MD 21502
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restlawn Memorial Gardens
20c. LOCATION — City or Town, State: LaVale, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James Scarpelli
22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Avenue, Cumberland, MD 21502

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Ventricular Arrythmia — DUE TO (OR AS A CONSEQUENCE OF): — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Previous Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF): — months
c. Generalized Arteriosclerosis — DUE TO (OR AS A CONSEQUENCE OF): — years
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: F. R. Miles Jr., M.D.
29c. LICENSE NUMBER: D07004
29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEORGE BREZA, M.D. BMG 912 SETON DRIVE CUMBERLAND , MD. 21502
31. DATE FILED (Month, Day, Year): OCT 30 1989
32. REGISTRAR'S SIGNATURE: Githa Davidson-Randall

DHMH-16 Rev 1/89

10

89 29876

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James W. Staup

2. DATE OF DEATH (Month, Day, Year): 10 25 1989

3. TIME OF DEATH: 6:30 a M

4. SOCIAL SECURITY NUMBER: 216-07-2762

5. SEX: 1 [X] M 2 [ ] F

6. BIRTHPLACE (State or Foreign Country): Md

8. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

7. DATE OF BIRTH (Month, Day, Year): 02/08/1911

9a. FACILITY NAME (If not institution, give street and number): Frostburg Community Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Frostburg, MD

9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Allegany

10c. CITY, TOWN OR LOCATION: Frostburg

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: Rd 1 Box 478

10f. ZIP CODE: 21532

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+): 0

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Paper

16b. KIND OF BUSINESS/INDUSTRY: Westvaco Corp.

17. FATHER'S NAME (First, Middle, Last): James H. Staup

18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Waddel

19a. INFORMANT'S NAME (Type/Print): Mrs. James Staup

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rd1, Box 478, Frostburg, Md. 21532

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Mem. Park

20c. LOCATION — City or Town, State: Frostburg, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jos E McKenzie

22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral hemorrhage (Massive) — 1 Week

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Hypertensive Cerebro Vascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia · Hypercalcemia
Pres hyperparathyroidism
Congestive heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S L Sandhir MD

29c. LICENSE NUMBER: D 14464

29d. DATE SIGNED (Month, Day, Year): ▶ 10/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sandhir, S. Lal M.D. 48 Tarn Terrace Frostburg, MD 21532

31. DATE FILED (Month, Day, Year): OCT 30 1989

32. REGISTRAR'S SIGNATURE: Julie Davidson-Kendall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page [illegible] should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29877

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPH LEWIS TUTWILER | | | | 2. DATE OF DEATH (Month, Day, Year): 10/12/989 | | 3. TIME OF DEATH: 9:45A M |
| 4. SOCIAL SECURITY NUMBER: 218600014 | 5. SEX: 1 [X] M 2 [ ] F | 5. AGE (In yrs. last birthday): 37 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): June 29, 1952 | 8. BIRTHPLACE (State or Foreign Country): West Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland | | 9c. COUNTY OF DEATH: ALLEGANY | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| W.Va. | Hampshire | Augusta | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Route 1 Box 194 | 26704 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Laborer | Asphalt Construction |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Henry Daniel Tutwiler | Clara Esther Smith |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Neva Jeanne Tutwiler | Rt. 1 Box 194 Augusta, W.Va. 26704 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Tearcoat Cemetery | Augusta, W.Va. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ James R. Ryder | McKee Funeral Home Augusta, W.Va. 26704 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CARDIOMYOPATHY | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY INSUFF, ACUTE RENAL FAILURE, LIVER FAILURE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [ ] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Robert Welik MD | D31875 | ▶ 10/12/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. ROBERT WELIK 921 SETON DRIVE CUMBERLAND, MD 21502

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 23 '89 | Julia Davidson-Randall |

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89 29878

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| CARL | DONALD | ZILER | OCTOBER 19, 1989 | 3:55A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-10-4884 | 1 [X] M 2 [ ] F | 81 YRS. | | | JUNE 20,1908 | MARYLAND |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Memorial Hospital | Cumberland | Allegany |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | ALLEGANY | RAWLINGS | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| MAPLE LANE | 21557 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 8 | | REFRIG.MAINT.WORKER | CELANESE FIBERS CORP. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JOHN W. ZILER | GRACE BAILEY |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| RONALD V. ZILER | ROUTE 1, BOX 85-E, MT. SAVAGE, MD 21545 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | HILLCREST BURIAL PARK | CUMBERLAND, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Wendy M. Upchurch | GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Renal Failure | 5 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CAD | yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. CVD | 5 yrs |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Generalized atherosclerosis | yrs. |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| John T. Whitmore MD | D19229 | ▶ 10-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dr. John T. Whitmore P. O. Box 3175 LaVale, MD. 21502

| 31. DATE FILED (Month, Day, Year) | 32. [illegible]'s Number |
|---|---|
| OCT 20 1989 | |

DHMH-16 Rev 1/89

89 29879

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be ... or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ... for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Samuel Ahmuty, Jr.
2. DATE OF DEATH — MONTH: 10 DAY: 14 YEAR: 89
3. TIME OF DEATH: 4:45 AM
4. SOCIAL SECURITY NUMBER: 219-16-0421
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-3-24
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: AA

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 221 Gibson Road
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: W W II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Postmaster
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): Samuel Ahmuty, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Charlotte Pratt
19a. INFORMANT'S NAME (Type/Print): Gladys B. Ahmuty
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 221 Gibson Road, Annapolis, MD 21401
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Nichols-Bethel Cemetery
20c. LOCATION — City or Town, State: Odenton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert S. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdisc or reepiratory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced metastatic Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Primary site - Signoid
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 10 14 89
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Stephen B. Hiltabidle MD
29c. LICENSE NUMBER: D05495
29d. DATE SIGNED (Month, Day, Year): 10/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen B. Hiltabidle, 801 Melvin Ave., Annapolis, MD 21401
31. DATE FILED (Month, Day, Year): OCT 16 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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ITEMS:23, 27 per ME G-658
12-22-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| CASSIE C. H. | ASBURY | 10-10-89 | 11:26PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 6. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| | 1 ☐ M 2 ☒ F | YRS. | | | Oct.9,1989 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| ANNE ARUNDEL GENERAL HOSPITAL | ANNAPOLIS | ANNE ARUNDEL COUNTY |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Crownsville | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 919 Hine Trail | 21032 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | ------ | ------ |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Frank B. Asbury | Rhonda Lewis |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Frank B. Asbury | 919 Hine Trail, Crownsville, MD 21032 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Hillcrest Cemetery | Annapolis, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Donald A. Taylor | Taylor Funeral Chapel 21401<br>147 Gloucester St.,Annapolis,MD |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. SEPSIS WITH EARLY PNEUMONIA | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX YES 2 ☐ NO | XX ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin MD | OCME | ▶ 10-12-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JULIA C. GOODIN,MD 111 PENN STREET, BALTIMORE,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 16 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ronald Alyward
2. DATE OF DEATH: MONTH 10 DAY 11 YEAR 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 036-05-6208
5. SEX: 1 ☐ M 2 ☐ F (XX)
6. AGE (In yrs. last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 05 19 1908
8. BIRTHPLACE (State or Foreign Country): Newfoundland

9a. FACILITY NAME (If not institution, give street and number): 250 Elkton So.
9b. CITY, TOWN OR LOCATION OF DEATH: Laurel
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Laurel
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 250 Eldton So.
10f. ZIP CODE: 20707
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) ; College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Police Officer
16b. KIND OF BUSINESS/INDUSTRY: City Police Dept.

17. FATHER'S NAME (First, Middle, Last): Matthew Alyward
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Carew

19a. INFORMANT'S NAME (Type/Print): Maureen A. Powers
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 250 Elton So. Laurel, Maryland 20707

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Charles Cemetery
20c. LOCATION — City or Town, State: Providence R.I.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, Md 20707

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be [illegible] the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Lung Cancer | 2 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | TOBACCO DEPENDENCY | 50 yrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D25422
29d. DATE SIGNED (Month, Day, Year): ▶ 10/12/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. MAGIN, MD LAUREL, MD

31. DATE FILED (Month, Day, Year): OCT 19 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(10)

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDNA I. ABEL
2. DATE OF DEATH (Month, Day, Year): 10 17 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 213-26-4960
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1 3 1931
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS
9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: ANNE ARUNDEL
10c. CITY, TOWN OR LOCATION: ANNAPOLIS
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1017 President Street
10f. ZIP CODE: 21403
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): LEWIS WEEM
18. MOTHER'S NAME (First, Middle, Maiden Surname): EDNA WILSON
19a. INFORMANT'S NAME (Type/Print): THOMAS ABEL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1017 President St. Annapolis, Md. 21403
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PINELAWN MEM. PARK
20c. LOCATION — City or Town, State: ANNAPOLIS, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Reese, II
22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md. 21401 — WILLIAM REESE & SONS MORTUARY, P.A.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF:
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Ruptured Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Approximate Interval Between Onset and Death

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D0045553
29d. DATE SIGNED (Month, Day, Year): ▶ 10/19/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] 1835 Forest Drive S.R. Annapolis MD
31. DATE FILED (Month, Day, Year): OCT 19 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29883

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles E Arthur | | | | 2. DATE OF DEATH (Month, Day, Year): 10 16 89 | 3. TIME OF DEATH: 1410 M |
| 4. SOCIAL SECURITY NUMBER: 212-16-3172 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 11-15-12 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CTR. | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | | 9c. COUNTY OF DEATH: ANNE ARUNDEL |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MARYLAND | ANNE ARUNDEL | ANNAPOLIS | 1 ☐ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 701 Glenwood Street | 21401 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced | 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 XX NO Specify: | Specify: BLACK |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | LABORER | U.S. NAVAL ACADEMY |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| JAMES ARTHUR | ELMIRA PINDELL |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| DONALD ARTHUR | 1610 Col-mar Lane Annapolis, Md. 21401 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | PINELAWN MEM. PARK | ANNAPOLIS, MARYLAND |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ William Reese, II | 821 West St. Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A. |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Cerebrovascular Accident | 2 hrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. Arteriosclerotic Vascular Disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. Diabetes Mellitus | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pneumonia Urinary Tract Infection

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☑ NO | HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| W Behrens MD | D36488 | ▶ 10/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 19 1989 | Jiska Davidson-Kendall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29884

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Betty Bock | | | 2. DATE OF DEATH (Month, Day, Year): 10 13 89 | 3. TIME OF DEATH: 2:30 PM |
| 4. SOCIAL SECURITY NUMBER: 212-34-3477 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 72 YRS. (If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): Mar. 5, 1917 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Chesapeake Manor Extended Care Centre | | 9b. CITY, TOWN OR LOCATION OF DEATH: Arnold | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 9 Cove of Cork Lane | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 5 + | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): William E. Kirk | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 700 Melvin Avenue, Annapolis, MD 21401 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey S. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma of the Nasopharynx and Floor of the Mouth

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ~~DUE TO (OR AS A CONSEQUENCE OF):~~

c. Stage IV Carcinoma of Breast

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Cyriac MD Medical Director | 29c. LICENSE NUMBER: D21684 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10.13.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. C. V. CYRIAC. M.D. 14 WELLHAM AVE, GLENBURNIE MD 21061.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 20 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

10

89 29885

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Albert O. BURDSALL — ALBERT / BURDSALL
2. DATE OF DEATH: MONTH 10 DAY 18 YEAR 89
3. TIME OF DEATH: 7:10 P M
4. SOCIAL SECURITY NUMBER: 578 26 7312
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): -- 4-11-10
8. BIRTHPLACE (State or Foreign Country): West VA
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Gen. Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Calvert
10c. CITY, TOWN OR LOCATION: Owings,
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1651 -- Paris Oaks Rd.
10f. ZIP CODE: 20736
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):
15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Doorman
16b. KIND OF BUSINESS/INDUSTRY: Hotel
17. FATHER'S NAME (First, Middle, Last): Edward Burdsall
18. MOTHER'S NAME (First, Middle, Maiden Surname): Amy Wieler
19a. INFORMANT'S NAME (Type/Print): Gerald J. Burdsall
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): same as 10 above
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cem.
20c. LOCATION — City or Town, State: Brentwood (PG) MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. Mitchell Phipps RFH
22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home Owings, MD 20736

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hesrt feilure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | SEPSIS | DAYS |
| DUE TO (OR AS A CONSEQUENCE OF): b. | URINARY TRACT INFECTION | ?2WKS |
| Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | RENAL FAILURE | ?1 MO |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Barry R. Nathanson MD
29c. LICENSE NUMBER: D23454
29d. DATE SIGNED (Month, Day, Year): ▶ 10/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARRY R. NATHANSON M.D. 51 FRANKLIN ST. ANNAPOLIS, MD 21401
31. DATE FILED (Month, Day, Year): OCT 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

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89 29886

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 5 should be used as the burial-transit permit. Pages 1, 2, 3 should
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE W. BERRY
2. DATE OF DEATH: MONTH 10 DAY 13 YEAR 87
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 214-05-1103
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 7, 1917
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1289 Virginia Avenue
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W W II
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fire Department
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): George Berry
18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace Carson
19a. INFORMANT'S NAME (Type/Print): Laura E. Berry
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1289 Virginia Ave., Annapolis, MD 21401
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest
20c. LOCATION — City or Town, State: Annapolis, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Tyler
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. A.S.C.V.D.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William P. Jones MD
29c. LICENSE NUMBER: D06054
29d. DATE SIGNED (Month, Day, Year): ▶ 10-13-87
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William P. Jones, MD. 695 America 21035
31. DATE FILED (Month, Day, Year): OCT 16 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

12+1

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Joel F. Barnes | | | 2. DATE OF DEATH (Month, Day, Year): 10-23-89 | 3. TIME OF DEATH: 10:30 AM |
| 4. SOCIAL SECURITY NUMBER: 315-26-4983 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 58 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 12-08-30 | 8. BIRTHPLACE (State or Foreign Country): Evanston, IL |
| 9a. FACILITY NAME (If not institution, give street and number): 1111 Collison Road | | 9b. CITY, TOWN OR LOCATION OF DEATH: Mayo | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Mayo | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1111 Collison Road | 10f. ZIP CODE: 21206 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: x | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 8+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Officer | 16b. KIND OF BUSINESS/INDUSTRY: US NAVY |
| 17. FATHER'S NAME (First, Middle, Last): Douglas A. Barnes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Goodwin | |
| 19a. INFORMANT'S NAME (Type/Print): Nancy W. Barnes | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1111 Collinson Road, Mayo, MD 21206 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington Nat'l. Cemetery | 20c. LOCATION — City or Town, State: Arlington, VA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul J Arnold | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgley Ave. Annapolis, MD 21401 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardiac arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. respiratory insufficiency | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. advanced, metastatic small cell lung carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter A. Cohen M.D | 29c. LICENSE NUMBER: D38304 | 29d. DATE SIGNED (Month, Day, Year): ▶ 24 October 1989 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. Cohen, M.D. Naval Hospital, Bethesda MD 20892 | | |
| 31. DATE FILED (Month, Day, Year): OCT 26 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Kindell | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NANCY S BARNSLEY
2. DATE OF DEATH — MONTH: 10 DAY: 28 YEAR: 89
3. TIME OF DEATH: 9:30 pm
4. SOCIAL SECURITY NUMBER: 231-34-5268
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04-06-31
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Churchton
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1222 Ellicott Avenue
10f. ZIP CODE: 20733
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Household
17. FATHER'S NAME (First, Middle, Last): Robert Henry Sherman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Freddie Irene Edmondson
19a. INFORMANT'S NAME (Type/Print): Robert Adams Barnsley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1222 Ellicott Ave. Churchton, MD 20733
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Riverview Cemetery
20c. LOCATION — City or Town, State: Strasburg, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas N Hardesty
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home p.A. 905 Galesville Rd, Galesville, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastatic Breast Cancer | 1 year |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: EW Cole
29c. LICENSE NUMBER: D16354
29d. DATE SIGNED (Month, Day, Year): ▶ 10/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): EW COLE III 51 FRANKLIN ST ANNAPOLIS MD 21401
31. DATE FILED (Month, Day, Year): OCT 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): SUSAN H. BAKER | | | | 2. DATE OF DEATH (Month, Day, Year): OCT 15 1989 | 3. TIME OF DEATH: 1250 M |
| 4. SOCIAL SECURITY NUMBER: 258-02-9856 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 31 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): JAN 29, 1958 | 8. BIRTHPLACE (State or Foreign Country): |
| 9a. FACILITY NAME (If not institution, give street and number): KIMBROUGH ARMY COMMUNITY HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: FT. MEADE, MD | | 9c. COUNTY OF DEATH: ANNE ARUNDEL |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Ft. George G. Meade | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7737 A Nelson Loop | | 10f. ZIP CODE: 20758 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): Warren Huntoon | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Norma Carter | |
| 19a. INFORMANT'S NAME (Type/Print): Kevin Baker | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7737 A Nelson Loop Ft. Meade 20758 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Indiantown Gap National Cem | 20c. LOCATION — City or Town, State: Annville, PA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] 7259 | | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Road Laurel, MD 20707 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. OVERDOSE WITH DESIPRAMINE | 9 DAYS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Juan B. Arguinzoni MD | 29c. LICENSE NUMBER: D23888 MD. | 29d. DATE SIGNED (Month, Day, Year): 15 Oct 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUAN B. ARGUINZONI | | |
| 31. DATE FILED (Month, Day, Year): OCT 19 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alice L. Brown
2. DATE OF DEATH: MONTH 10 DAY 23 YEAR 89
3. TIME OF DEATH: 9 30 A M
4. SOCIAL SECURITY NUMBER: 220-24-3291
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/12/20
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS
9c. COUNTY OF DEATH: ANNE ARUNDEL

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 37 Bunche ST
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ✓ — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautician
16b. KIND OF BUSINESS/INDUSTRY: Cosmetology
17. FATHER'S NAME (First, Middle, Last): Oden MacKell
18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE WILSON
19a. INFORMANT'S NAME (Type/Print): BEVERLY DOWNS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 27 Bunche St. Annapolis, Md. 21401
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HOPE U.M. CHURCH CEMETERY
20c. LOCATION — City or Town, State: EDGEWATER, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Larry H. Reese
22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md. 21401 — WILLIAM REESE & SONS MORTUARY, P.A.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory ARREST | minutes |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Lung CA | 1 yr |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John D. Jackson MD
29c. LICENSE NUMBER: D30718
29d. DATE SIGNED (Month, Day, Year): ▶ 10-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN D JACKSON 1833 COAST DR, ANNAPOLIS MD 21401
31. DATE FILED (Month, Day, Year): OCT 24 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29891

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CAROLINE L. COLE | | | 2. DATE OF DEATH (Month, Day, Year): Oct. 27, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 213-50-6096 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 24, 1915 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 112 Archwood Avenue | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas J. Cole, Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen J. Quinn | | |
| 19a. INFORMANT'S NAME (Type/Print): Clara A. Cole | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 Archwood Avenue, Annapolis, MD 21401 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myelocytic leukemia | 2 mos |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Stuart E. Selonick, MD | 29c. LICENSE NUMBER: D19838 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 51 Franklin St. #420 Annapolis, Md. 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rebekah R. Clare | | 2. DATE OF DEATH (Month, Day, Year): October 24, 1989 | 3. TIME OF DEATH: 4:47 P M |
| 4. SOCIAL SECURITY NUMBER: 217-07-0355D | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 20, 1908 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 1213 Montgomery Rd. | 9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie | 9c. COUNTY OF DEATH: Anne Arundel | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Glen Burnie | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1213 Montgomery Rd. | 10f. ZIP CODE: 21061 | 10g. CITIZEN OF WHAT COUNTRY?: United States | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Own Home | |
| 17. FATHER'S NAME (First, Middle, Last): William G. Rees | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Zimmerly | | |
| 19a. INFORMANT'S NAME (Type/Print): Jeannette White | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1075 Minnetonka Rd., Severn, Maryland 21144 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glen Haven Memorial Park | 20c. LOCATION — City or Town, State: Glen Burnie, A.A., MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home, 421 Crain Hwy. S.E., Glen Burnie, MD 21061 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Respiratory failure | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Carcinoma of lung. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | Arrythmia, CHF, | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HTN.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Shobha Reddy MD | D30568 | ▶ October 25, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHOBHA REDDY, 300 HOSP. DRIVE, SUITE 230, GLEN BURNIE 21061

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 26 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29893

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): EVELYN CARR | | | 2. DATE OF DEATH (Month, Day, Year): Oct. 25 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 6 6 1913 | 8. BIRTHPLACE (State or Foreign Country): MAARYLAND |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CENTER | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | 9c. COUNTY OF DEATH: ANNE ARUNDEL |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: ANNAPOLIS | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1401 Hayes Road | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: BLACK |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC | 16b. KIND OF BUSINESS/INDUSTRY: CARLTON MITCHEL FAMILY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): GEORGE M. HAYES, Sr. | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIE JOHNSON |

| | |
|---|---|
| 19a. INFORMANT'S NAME (Type/Print): LORRAINE CARR | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1401 Hayes Rd. Annapolis, Md. 21401 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ASBURY BROADNECK CHURCH CEME. | 20c. LOCATION — City or Town, State: St. Margarets, Md. |

| | |
|---|---|
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William Reese, II | 22. NAME AND ADDRESS OF FACILITY: 821 West St. Annapolis, Md 21401 WILLIAM REESE & SONS MORTUARY, P.A. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: H.D. Goldstein | 29c. LICENSE NUMBER: D26743 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H.D. GOLDSTEIN

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 27 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29894

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Robert Wesley Critzer
2. DATE OF DEATH (Month, Day, Year): 10-27-89
3. TIME OF DEATH: 0709 M
4. SOCIAL SECURITY NUMBER: 231-44-3254
5. SEX: 1 [X] M 2 [ ] F
6. AGE (If under last birthday): 51 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-19-37
8. BIRTHPLACE (State or Foreign Country): USA, Virginia
9a. FACILITY NAME (If not institution, give street): Kimbrough Army Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Ft. Meade
9c. COUNTY OF DEATH: AnneArundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Odenton
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 944 Patuxent Road
10f. ZIP CODE: 21113
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 1979
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Ret. Sgt..
16b. KIND OF BUSINESS/INDUSTRY: US Army
17. FATHER'S NAME (First, Middle, Last): Atwell Critzer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Willie Collins
19a. INFORMANT'S NAME (Type/Print): Helga Sophia Critzer
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 944 Patuxent Road, Odenton, MM 21113
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crownsville CemeteryVeterans, Crownsville, MD
20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Ralph J Hardesty
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 851 Annapolis Road, Gambrills, MD

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF): ASCVD

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William R Jones MD Deputy
29c. LICENSE NUMBER: D06054
29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William R Jones 695 America 21055

31. DATE FILED (Month, Day, Year): OCT 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29895

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOUGLAS WELCH CATTERTON
2. DATE OF DEATH (Month, Day, Year): Oct. 22, 1989
3. TIME OF DEATH: P. M
4. SOCIAL SECURITY NUMBER: 218-26-0577
5. SEX: 1 ☐ M 2 ☐ F (XX)
6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 11-17-1925
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Harwood
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 15 Polling House Road
10f. ZIP CODE: 20776
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 3 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter
16b. KIND OF BUSINESS/INDUSTRY: House, Construction
17. FATHER'S NAME (First, Middle, Last): Elliot Catterton
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary AmandaBassford
19a. INFORMANT'S NAME (Type/Print): Doris P. Catterton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15 Polling House Rd. Harwood, Md. 20776
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion
20c. LOCATION — City or Town, State: Lothian, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert A. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel Annapolis, Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | congestive heart failure | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Ischemic cardiomyopathy | |
| c. DUE TO (OR AS A CONSEQUENCE OF): | ASCVD | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: R Peeler
29c. LICENSE NUMBER: D18809
29d. DATE SIGNED (Month, Day, Year): ▶ Oct 24, 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard N. Peeler, Franklin St. Annapolis, MD. 21401
31. DATE FILED (Month, Day, Year): OCT 24 1989
32. REGISTRAR'S SIGNATURE: Jiha Davidson-Kendall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROXANA HELEN DAY
2. DATE OF DEATH (Month, Day, Year): Oct. 27, 1989
3. TIME OF DEATH: 1025 AM
4. SOCIAL SECURITY NUMBER: 216-28-1905
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan. 23, 1904
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Annapolis Convalescent Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 701 Glenwood Street
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner
16b. KIND OF BUSINESS/INDUSTRY: Restaurant

17. FATHER'S NAME (First, Middle, Last): William Thomas Kelly
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Wiggins

19a. INFORMANT'S NAME (Type/Print): Joan D. Wilkinson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 156 Cardamon Drive, Edgewater, MD 21037

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Bluff
20c. LOCATION — City or Town, State: Annapolis, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald L. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pneumonia Arrest 2° | 1 wk |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Hip fractures | several wks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Dementia | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: 031188
29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R COLTON

31. DATE FILED (Month, Day, Year): OCT 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 29897

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be ... for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Charles Edward Dove
2. DATE OF DEATH (Month, Day, Year): 10 12 89
3. TIME OF DEATH: 7 AM
4. SOCIAL SECURITY NUMBER: 579-28-9850
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 65 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): June 28, 1924
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1559 Lodge Pole Court
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1559 Lodge Pole Court
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer
16b. KIND OF BUSINESS/INDUSTRY: Agriculture
17. FATHER'S NAME (First, Middle, Last): Joseph Franklin Dove
18. MOTHER'S NAME (First, Middle, Maiden Surname): Leona Maxwell
19a. INFORMANT'S NAME (Type/Print): Dorothy Louise Dove
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1559 Lodge Pole Court, Annapolis, MD 21401
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Christ Church Cemetery
20c. LOCATION — City or Town, State: Owensville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randal S. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CORONARY INSufficiency | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: alcoholism; seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas Walsh M
29c. LICENSE NUMBER: D23867
29d. DATE SIGNED (Month, Day, Year): ▶ 10-12-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas M. Walsh, M.D., 269 Peninsula Farm Lane, Arnold, MD 21012
31. DATE FILED (Month, Day, Year): OCT 16 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page ___ should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MATTHEW J DOUGHERTY | | | 2. DATE OF DEATH: MONTH 10 – DAY 17 – YEAR 89 | 3. TIME OF DEATH: 6:50 PM |
| 4. SOCIAL SECURITY NUMBER: 578-32-2759 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03-06-26 | 8. BIRTHPLACE (State or Foreign Country): Washington, DC |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Lothian | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 312 Bert Drive | | 10f. ZIP CODE: 20766 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1945-46 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Electrician | 16b. KIND OF BUSINESS/INDUSTRY: Fed. Gov't. | |
| 17. FATHER'S NAME (First, Middle, Last): Daniel P. Dougherty | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret McLoughlin | |
| 19a. INFORMANT'S NAME (Type/Print): Marguerite Malkie | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 Bear Creek Pkwy. Edgewater, MD 21037 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery | 20c. LOCATION — City or Town, State: Davidsonville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Metastatic CA Carcinoma of the Esophagus — 1 yr.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Esophagus
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURRED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] R COLLISON | 29c. LICENSE NUMBER: D31188 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 103 Gibson Ave Annapolis MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): OCT 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

6 of 1

89 29899

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician for its permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for [illegible] be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HERBERT F. ECKBERG | | | 2. DATE OF DEATH (Month, Day, Year): 10 14 89 | 3. TIME OF DEATH: 2 AM |
| 4. SOCIAL SECURITY NUMBER: 165-32-8575 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 19, 1906 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): 1927 Pendennis Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1927 Pendennis Drive | | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II-Korea | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 5 + | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U.S. Navy | | 16b. KIND OF BUSINESS/INDUSTRY: Defense |
| 17. FATHER'S NAME (First, Middle, Last): Arvid W. Eckberg | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Lumdquist | | |
| 19a. INFORMANT'S NAME (Type/Print): Ellen V. Eckberg | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1927 Pendennis Drive, Annapolis, MD 21401 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): U.S. Naval Academy Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor Jr. | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 147 Gloucester St., Annapolis, MD 21401 | | | |

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASP, chronic illness, CA - Maddox

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| W. A. Dabbs | AD18078B | ▶ 10/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DABBS, W. A. 703 Giddings Ave Annapolis.

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 16 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

13+1
29+1

89 29900

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Boy Frank
2. DATE OF DEATH (Month, Day, Year): 10 - 25 - 89
3. TIME OF DEATH: 7:40 A M
4. SOCIAL SECURITY NUMBER: —
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (If yrs. last birthday): — YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. 15
7. DATE OF BIRTH (Month, Day, Year): 10-25-89
8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel Co.

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Edgewater
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 1102 Murray Dr.
10f. ZIP CODE: 21037
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): —
16b. KIND OF BUSINESS/INDUSTRY: —
17. FATHER'S NAME (First, Middle, Last): John Taylor Frank
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marisa De Luca
19a. INFORMANT'S NAME (Type/Print): Marisa Frank
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1102 Murray Dr. Edgewater, Md. 21037
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory
20c. LOCATION — City or Town, State: Balt. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home, Ann. Md.

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. prematurity
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. premature rupture of membranes
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1517 RITCHIE HWY ARNOLD MD 21012

31. DATE FILED (Month, Day, Year): OCT 30 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kindell

DHMH-18 Rev 1/89

89 29901

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LEONARD BELMONT GREENE | | | 2. DATE OF DEATH (Month, Day, Year): Oct 10 1989 | 3. TIME OF DEATH: 6:15 P M |
| 4. SOCIAL SECURITY NUMBER: 459-30-1496 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 62 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11 15 26 | 8. BIRTHPLACE (State or Foreign Country): Texas |
| 9a. FACILITY NAME (If not institution, give street and number): 994 Bayberry Drive | | 9b. CITY, TOWN OR LOCATION OF DEATH: Arnold | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Arnold | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 994 Bayberry Drive | | 10f. ZIP CODE: 21012 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean Conflict | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): system analyst | 16b. KIND OF BUSINESS/INDUSTRY: Navy |
| 17. FATHER'S NAME (First, Middle, Last): Derwood B. Greene | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Graffio Halloran | |
| 19a. INFORMANT'S NAME (Type/Print): Anne L. Greene | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1108 Nancy St., Easton MD 21601 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify) _____ 11/17/89 | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Spring Hill Cemetery | 20c. LOCATION — City or Town, State: Easton, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ M. E. Newnam III | | 22. NAME AND ADDRESS OF FACILITY: Newnam Funeral Home Easton, Maryland | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Prostrate Cancer | Months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] ND | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James Chaconas M.D. | 29c. LICENSE NUMBER: D16964 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Chaconas, M.D. 1509 Ritchie Highway, Arnold MD 21012

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 12 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

20

89 29902

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIAN R. GREER | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 19 / 89 | 3. TIME OF DEATH: 10:55 PM |
| 4. SOCIAL SECURITY NUMBER: 381-14-2515 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 1-17-1924 | 8. BIRTHPLACE (State or Foreign Country): Michigan |
| 9a. FACILITY NAME (If not institution, give street and number): Chesapeake Manor Care Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Arnold | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Mich | 10b. COUNTY: Rescommon | 10c. CITY, TOWN OR LOCATION: Houghton Lake | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 743 Old Trail Drive | | 10f. ZIP CODE: 48629 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bank Manager | 16b. KIND OF BUSINESS/INDUSTRY: Banking | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Weiss | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Vanschoiack | |
| 19a. INFORMANT'S NAME (Type/Print): Kurt Roll | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1241 Ramblewood Dr. Annapolis, Md. 21401 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Riverside Cemetery | 20c. LOCATION — City or Town, State: Three Rivers, Mich. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert A. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel Annapolis, Md. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Metastate Carcinoma of the | |
| DUE TO (OR AS A CONSEQUENCE OF): | Urinary Bladder | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Cyriac MD Medical Director | 29c. LICENSE NUMBER: D21684 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-20-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C V CYRIAC MD. 14 WELLHAM AVE, GLENBURNIE. MD 21061.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

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89 29903

Item:23 thru 27 per ME G-657
11-24-89 cm

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| SUZANNE | LOUISE | HARPER | 10 / 10 / 1989 | 7:21 AM |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 217-50-7698 | 1 ☐ M 2 ☒ F | 45 YRS. | | | Nov. 25, 1943 | New York |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Anne Arundel General Hospital | Annapolis | Anne Arundel |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 3 Cove of Cork Lane | 21401 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| | 2 | Homemaker | Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| R. H. Smith | Doris Freeman |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Douglas J. Harper | 3 Cove of Cork Lane, Annapolis, MD 21401 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Metropolitan | Alexandria, VA |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Taylor Funeral Chapel 21401<br>147 Gloucester St., Annapolis, MD |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Spontaneous Dissection of the Coronary Arteries | |
| | DUE TO (OR AS A CONSEQUENCE OF): Idiopathic | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| ☒ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | OCME | ▶ 10-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Frank J. Peretti, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 16 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified on page 5.**

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89 29904

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOHN FARRELL HOEFT | | | 2. DATE OF DEATH (Month, Day, Year): 10-24-89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 225-10-3205 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 6, 1916 | 8. BIRTHPLACE (State or Foreign Country): Washington D.C. |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1017 Pinecrest Drive | | 10f. ZIP CODE: 21403 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W W II | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Representative | 16b. KIND OF BUSINESS/INDUSTRY: Marine and Industrial Plywood |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Joseph A. Hoeft | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Gertrude McTernan |
| 19a. INFORMANT'S NAME (Type/Print): Frances R. Hoeft | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1017 Pinecrest Drive, Annapolis, MD 21403 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Presbyterian Cemetery | 20c. LOCATION — City or Town, State: Alexandria, VA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald L. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Massive left Cortical cerebral infarction | 10 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Severe Hypertensive cardio-vascular disease | years. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Previous right Cerebral infarction.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Peter F. VERKOUW MD | 29c. LICENSE NUMBER: D11653 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-25-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Peter F. VERKOUW 1833 Forest Drive Annapolis 21401 | | |
| 31. DATE FILED (Month, Day, Year): OCT 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

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89 29905

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached (or perforated) as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified before ...**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Wilda Roberts Hildebrand
2. DATE OF DEATH (Month, Day, Year): Oct. 9, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 577-20-7645
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 19, 1899
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 130 Hearne Road
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Elwin Lee Roberts
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Leota Kaufmann
19a. INFORMANT'S NAME (Type/Print): Carroll G. Hildebrand
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 440 Wagaman Circle, Annapolis, MD 21403
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): National Memorial Park
20c. LOCATION — City or Town, State: Falls Church, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert A. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. left hemiparalysis — ± 1 week

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. right cerebral infarction — ± 1 week.

DUE TO (OR AS A CONSEQUENCE OF):

c. _____

DUE TO (OR AS A CONSEQUENCE OF):

d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

= None - except for age.
= Past history of heart - infarct

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D11653
29d. DATE SIGNED (Month, Day, Year): 10-12-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PETER F. VERKOUW 1833 Forest Dr. Annapolis, Md. 21401
31. DATE FILED (Month, Day, Year): OCT 16 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 29906

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for ... burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Rupert Swetland Huntington | | 2. DATE OF DEATH (Month, Day, Year): Oct. 13, 1989 | 3. TIME OF DEATH: A. M |
| 4. SOCIAL SECURITY NUMBER: 086-18-3307 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Jan. 20, 1923 |
| 8. BIRTHPLACE (State or Foreign Country): Pennsylvania | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Pleasant Living Convalescent Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Edgewater | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO |
| 10e. STREET AND NUMBER: 45 Maryland Avenue | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korea | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Hardware Store |
| 17. FATHER'S NAME (First, Middle, Last): Eleazer Peck Huntington | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Blanche Swetland | |
| 19a. INFORMANT'S NAME (Type/Print): Samuel L. Huntington | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4811 Avery Road, Shady Side, MD 20764 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan | 20c. LOCATION — City or Town, State: Alexandria, Va. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert S. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Rectal Carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jon Bowie MD | 29c. LICENSE NUMBER: D18529 | 29d. DATE SIGNED (Month, Day, Year): 13 Oct 89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): 77 West St. Annapolis, MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): OCT 16 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-15 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**1. DECEDENT'S NAME** (First, Middle, Last): Ruth J. Hardesty

**2. DATE OF DEATH** (Month, Day, Year): Oct. 13, 1989

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 216-36-7115 B

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 88 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): July 19,1901

**8. BIRTHPLACE** (State or Foreign Country): Massachusetts

**9a. FACILITY NAME** (If not institution, give street and number): Pleasant Living Convalescent Center

**9b. CITY, TOWN OR LOCATION OF DEATH**: Edgewater

**9c. COUNTY OF DEATH**: Anne Arundel

### RESIDENCE OF DECEDENT

**10a. STATE**: Maryland

**10b. COUNTY**: Anne Arundel

**10c. CITY, TOWN OR LOCATION**: Harwood

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 3844 Hardesty Road

**10f. ZIP CODE**: 20776

**10g. CITIZEN OF WHAT COUNTRY?** U. S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE** — American Indian, Black, White, etc. Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

**16b. KIND OF BUSINESS/INDUSTRY**: Home

**17. FATHER'S NAME** (First, Middle, Last): Alfred Care

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Mattie McKinsey

**19a. INFORMANT'S NAME** (Type/Print): Winterson Hardesty

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3844 Hardesty Road, Harwood, MD 20776

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): All Hallows Church Cemetery

**20c. LOCATION** — City or Town, State: Birdsville, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Donald A. Ley [signature]

**22. NAME AND ADDRESS OF FACILITY**: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY FUNERAL DIRECTOR

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | Cause | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Arteriosclerotic cardiovascular dis. | 22 years |
| DUE TO (OR AS A CONSEQUENCE OF): b. | — | |
| DUE TO (OR AS A CONSEQUENCE OF): c. | — | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | — | |

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cerebral infarctions, multiple, small

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year):

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**:

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify):

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State):

**29a. CERTIFIER** (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Charles W. Kinzer [signature]

**29c. LICENSE NUMBER**: D05928

**29d. DATE SIGNED** (Month, Day, Year): October 16, 1989

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Charles W. Kinzer, Forest Drive, Annapolis, MD

**31. DATE FILED** (Month, Day, Year): OCT 16 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Rendell [signature]

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the rural-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ARTHUR H. JACKSON | | 2. DATE OF DEATH (Month / Day / Year): Oct 15 89 | 3. TIME OF DEATH: 0325 AM |
| 4. SOCIAL SECURITY NUMBER: 289-01-4045 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 72 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): Dec. 16, 1916 |
| 8. BIRTHPLACE (State or Foreign Country): Indiana | | | |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL MEDICAL CTR | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS, MD | 9c. COUNTY OF DEATH: ANNE ARUNDEL | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 22 Oak Court | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: W W II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter | 16b. KIND OF BUSINESS/INDUSTRY: Construction | |
| 17. FATHER'S NAME (First, Middle, Last): Charles Jackson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lola Bocock | |
| 19a. INFORMANT'S NAME (Type/Print): Doris Marie Jackson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 22 Oak Court, Annapolis, MD 21401 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Emphysema | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert T Peterson | 29c. LICENSE NUMBER: D24804 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/15/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert T. Peterson, M.D., 130 Holiday Court, #101, Annapolis, MD 21401 | | |
| 31. DATE FILED (Month, Day, Year): OCT 16 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MILDRED Ann JORGENSON | | | 2. DATE OF DEATH (Month, Day, Year): October 13, 1989 | 3. TIME OF DEATH: 9:50 AM |
| 4. SOCIAL SECURITY NUMBER: 186-14-4561 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-28-19 | 8. BIRTHPLACE (State or Foreign Country): Scranton, PA. |
| 9a. FACILITY NAME (If not institution, give street and number): 3563 Ft. Meade Road #321 | | 9b. CITY, TOWN OR LOCATION OF DEATH: Laurel | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Laurel | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 3563 Ft. Meade Road #321 | | 10f. ZIP CODE: 20707 | | 10g. CITIZEN OF WHAT COUNTRY?: USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | | 16b. KIND OF BUSINESS/INDUSTRY: Government |
| 17. FATHER'S NAME (First, Middle, Last): Richard A. O'Hora | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Meher | | |
| 19a. INFORMANT'S NAME (Type/Print): Barbara A. Jeffers | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 355 Cecilton South Laurel, Maryland 20707 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ivy Hill Cemetery | | 20c. LOCATION — City or Town, State: Laurel, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. PROBABLE MYOCARDIAL INFARCTION
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CORONARY ARTERY DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
c. DIABETES MELLITUS
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PERIPHERAL VASCULAR DISEASE
PERIPHERAL NEUROPATHY (DIABETIC)

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] MD | D 22755 | ▶ 10.15.89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
CHRISTINE DE LIMA MD 14201 LAUREL PK DR #116 LAUREL MD 20707

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 19 '89 | Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 is the burial-transit permit. Pages 1, 2, 3 should be used as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

### TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annie Collison Jackson
2. DATE OF DEATH (Month, Day, Year): 10/14/89
3. TIME OF DEATH: 5:25pm M
4. SOCIAL SECURITY NUMBER: 216-09-3779
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/08/99
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Severna Park
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Severna Park
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: Meridian Nursing Center
10f. ZIP CODE: 21146
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales
16b. KIND OF BUSINESS/INDUSTRY: Department Store
17. FATHER'S NAME (First, Middle, Last): Frank Lee Brashears
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nan Collison
19a. INFORMANT'S NAME (Type/Print): Mr. Lester L. Jackson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1006 Cowpens Rd. Severna Park MD 21146 — Md 21204 Towson
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mayo Methodist Cem.
20c. LOCATION — City or Town, State: Mayo, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John A. Barranco
22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146

### TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cachexia of malignancy.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Carcinoma of Lung.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Atherosclerotic Heart disease Degenerative arthritis.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jose Romero (Samaras)
29c. LICENSE NUMBER: D0 83141
29d. DATE SIGNED (Month, Day, Year): ▶ 10/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 265 Ridgely Ave Annapolis, MD 21401

31. DATE FILED (Month, Day, Year): OCT 17 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

89 29911

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be [illegible] to use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen M. Kroehler
2. DATE OF DEATH (Month, Day, Year): 10/16/89
3. TIME OF DEATH: 4:45a M
4. SOCIAL SECURITY NUMBER: 082-60-7533
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05/15/99
8. BIRTHPLACE (State or Foreign Country): NB
9a. FACILITY NAME (If not institution, give street and number): 65 Robinson Landing Road
9b. CITY, TOWN OR LOCATION OF DEATH: Severna Park
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Severna Park
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 65 Robinson Landing Road
10f. ZIP CODE: 21146
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Charles Weymueller
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lena Unknown
19a. INFORMANT'S NAME (Type/Print): Mrs. Jane Lorenzen
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 65 Robinson Landing RoadSeverna Park MD 21146
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pinelawn Natl. Cem.
20c. LOCATION — City or Town, State: Long Island, NY
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Stroke | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D16964
29d. DATE SIGNED (Month, Day, Year): 10/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Arnold Family Practice 1509 Ritchie Highway, Arnold MD 21012
31. DATE FILED (Month, Day, Year): OCT 17 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

5

89 29912

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Charles C. Kretkowski | | | | 2. DATE OF DEATH (Month, Day, Year): 10-16-89 | 3. TIME OF DEATH: 10:15 A M |
| 4. SOCIAL SECURITY NUMBER: 056-09-6703 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 03-02-13 | 8. BIRTHPLACE (State or Foreign Country): Bayonne, NJ |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: NJ | 10b. COUNTY: Hudson | 10c. CITY, TOWN OR LOCATION: Bayonne | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 185 West 25th Street | 10f. ZIP CODE: 07002 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Vice President | 16b. KIND OF BUSINESS/INDUSTRY: Zerox Co. | |
| 17. FATHER'S NAME (First, Middle, Last): Stephen Kretkowski | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Anastasia Gorecki | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Kretkowski | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 185 West 25th Street, Bayonne, NJ 07002 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Cross Cemetery | 20c. LOCATION — City or Town, State: N. Arlington, NJ | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgley Ave. Annapolis, MD 21401 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE MYOCARDIAL INFARCTION | 1 Hr. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CORONARY ARTERY DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. [illegible] | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 5 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 5 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | 29c. LICENSE NUMBER: D14799 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K.S. MATHEW · 5510 KENILWORTH AVE. RIVERDALE. MD 20737 | | |
| 31. DATE FILED (Month, Day, Year): OCT 18 1989 | 32. REGISTRAR'S SIGNATURE: Erika Davidson-Mundell | |

DHMH-16 Rev 1/89

89 29913

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Marie P KROMAS | | | | 2. DATE OF DEATH (Month, Day, Year): October 21 1989 | 3. TIME OF DEATH: 7:00 A M |
| 4. SOCIAL SECURITY NUMBER: 579-18-3286 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Aug. 21, 1896 | 8. BIRTHPLACE (State or Foreign Country): Pennaylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Edgewater | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 144 Washington Road | | 10f. ZIP CODE: 21037 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | |
| 17. FATHER'S NAME (First, Middle, Last): Unknown | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown | |
| 19a. INFORMANT'S NAME (Type/Print): Philip E. Kromas | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 609 W. Wilson Creek Drive, New Bern, NC 28562 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mayo Memorial Church Cem. | 20c. LOCATION — City or Town, State: Mayo, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harold A. LyLes | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Peritonitis | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Bowel perforation | 1 week |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Bowel ischemia / infarction | 3 weeks |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. Atherosclerosis | years |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease, gangrene left foot.
Dehydration
Chronic urinary tract infection

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Charles W. Kinzer | 29c. LICENSE NUMBER: D05928 | 29d. DATE SIGNED (Month, Day, Year): October 21, 1989 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles W. Kinzer MD 1833A Forest Drive, Annapolis, MD 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

6

89 29914

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1. DECEDENT'S NAME (First, Middle, Last): Raymond Elwood Kraft
2. DATE OF DEATH (Month, Day, Year): 10-11-89
3. TIME OF DEATH: 4:51 A M
4. SOCIAL SECURITY NUMBER: 578-10-0084
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 07-21-11
8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Edgewater
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 432 Walnut Drive
10f. ZIP CODE: 21037
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic
16b. KIND OF BUSINESS/INDUSTRY: Bus Lines
17. FATHER'S NAME (First, Middle, Last): Phillip Kraft Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Cardoza
19a. INFORMANT'S NAME (Type/Print): Ronald E. Kraft
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 432 Walnut Drive, Edgewater, MD 21037
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery
20c. LOCATION — City or Town, State: Davidsonville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas J Hardesty
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest — DUE TO (OR AS A CONSEQUENCE OF): — 20 min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery Disease — DUE TO (OR AS A CONSEQUENCE OF):
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Probable CA Colon with Partial Bowel Obstruction

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D25178
29d. DATE SIGNED (Month, Day, Year): ▶ 10/11/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MOORE, ROBERT 130 Holiday Ct, St. 106, Annapolis 21401
31. DATE FILED (Month, Day, Year): 10/OCT/12 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY E. KNOX | | | 2. DATE OF DEATH (Month, Day, Year): 10 20 89 | 3. TIME OF DEATH: 950 PM |
| 4. SOCIAL SECURITY NUMBER: 378-34-7920 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 02 16 30 | 8. BIRTHPLACE (State or Foreign Country): MICHIGAN |
| 9a. FACILITY NAME (If not institution, give street and number): ANNE ARUNDEL GENERAL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: ANNAPOLIS | | 9c. COUNTY OF DEATH: ANNE ARUNDEL |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: SEVERNA PARK | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 103 ST. ANDREWS ROAD | | 10f. ZIP CODE: 21146 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4 | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EXECUTIVE | 16b. KIND OF BUSINESS/INDUSTRY: SALES |
| 17. FATHER'S NAME (First, Middle, Last): LAWRENCE MONTICELLO | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): LENA MANZETTI | |
| 19a. INFORMANT'S NAME (Type/Print): R.DAVE KNOX | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 ST. ANDREWS RD. SEVERNA PARK, MD. 21146 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY, INC. | 20c. LOCATION — City or Town, State: CATONSVILLE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary L. Kaufmann | | 22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Colon Cancer | 10 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO N/A. |

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] | 29c. LICENSE NUMBER: D16354 | 29d. DATE SIGNED (Month, Day, Year): 10/20/89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 51 FRANKLIN ST ANNAP. MD 2140[illegible] | | |
| 31. DATE FILED (Month, Day, Year): OCT 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Bella Love | | | 2. DATE OF DEATH (Month, Day, Year): 10-15-89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 211-16-0908 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11-29-99 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Ginger Cove | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Household | |
| 17. FATHER'S NAME (First, Middle, Last): Samuel Lavinsky | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Nemirofsky | |
| 19a. INFORMANT'S NAME (Type/Print): Stanley Love | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 62 E Lake Drive, Annapolis, MD 21403 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Har Zion Cemetery | 20c. LOCATION — City or Town, State: Collingdale, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Patt J Ardis | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgley Ave. Annapolis, MD 21401 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA —

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. acute MI —

DUE TO (OR AS A CONSEQUENCE OF):

c. pulmonary edema

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Jack Lechtenstein, MD | 29c. LICENSE NUMBER: D-08194 | 29d. DATE SIGNED (Month, Day, Year): ▶ |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jack Lechtenstein, MD | | |
| 31. DATE FILED (Month, Day, Year): OCT 17 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thelma Lamivel
2. DATE OF DEATH: MONTH 10 DAY 15 YEAR 89
3. TIME OF DEATH: 11:20 A M
4. SOCIAL SECURITY NUMBER: 579-26-9160
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN.
7. DATE OF BIRTH (Month, Day, Year): 8-4-1906
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Chesapeake Manor Extended Care
9b. CITY, TOWN OR LOCATION OF DEATH: Arnold
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1317 Homewood Lane
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant
16b. KIND OF BUSINESS/INDUSTRY: Food Service
17. FATHER'S NAME (First, Middle, Last): Rice E. Green
18. MOTHER'S NAME (First, Middle, Maiden Surname): Callie J. Wood
19a. INFORMANT'S NAME (Type/Print): Patricia Glennie
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1317 Homewood Lane Annapolis, Md. 21401
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan
20c. LOCATION — City or Town, State: Alexandria, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert A Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel Annapolis Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Advanced Chronic Obstructive Pulmonary Disease
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

Approximate Interval Between Onset and Death:

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: C. Cyriac MD. Medical Director
29c. LICENSE NUMBER: D21684
29d. DATE SIGNED (Month, Day, Year): ▶ 10-19-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. C. V. CYRIAC-M.D. 14 WELLHAM AVE N.W. GLENBURNIE - MD 21061-
31. DATE FILED (Month, Day, Year): OCT 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELSIE COMO MILLER
2. DATE OF DEATH (Month, Day, Year): 10 24 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 220-16-4356
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5-6-1904
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Chesapeake Manor Care Center
9b. CITY, TOWN OR LOCATION OF DEATH: Arnold
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annpolis
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ ND
10e. STREET AND NUMBER: 1380 Cape St. Claire Road
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ ND — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ ND Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Retail Grocery
17. FATHER'S NAME (First, Middle, Last): Roland N. Como
18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy Drury
19a. INFORMANT'S NAME (Type/Print): William J. Willians Jr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3615 Moonvine Crt. W.Palm Beach, Fla. 33406
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Bluff Cemetery
20c. LOCATION — City or Town, State: Annppolis, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert L. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel Annapolis, Md.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiogenic Shock | 6Hrs. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Arteriosclerotic cardiovascular disease | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic pyelonephritis
Chronic renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ND
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D 12452
29d. DATE SIGNED (Month, Day, Year): ▶ 10/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 5 E Franklin St, Annapolis, Md 21
31. DATE FILED (Month, Day, Year): 10 OCT 27 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donald Earl MacLean | | | 2. DATE OF DEATH (Month, Day, Year): Oct. 11, 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 007-03-5777 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): June 26, 1915 | 8. BIRTHPLACE (State or Foreign Country): Maine |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Edgewater | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 152 Hawks Bill Way | | 10f. ZIP CODE: 21037 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W W II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cobbler | 16b. KIND OF BUSINESS/INDUSTRY: Shoe Factory | |
| 17. FATHER'S NAME (First, Middle, Last): Blair MacLean | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bernice Caraveaux | |
| 19a. INFORMANT'S NAME (Type/Print): Sandra New | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 152 Hawks Bill Way, Edgewater, MD 21037 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cheltenham Veterans | 20c. LOCATION — City or Town, State: Cheltenham, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald E. Taylor | | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiac Arrest - M.I. | Brief |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D25812 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jack Teitelbaum, M.D., 139 Old Solomons Island Rd., Annapolis, MD 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 16 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Elsie Mister (Elizabeth / Mister)
2. DATE OF DEATH — MONTH: October DAY: 17, YEAR: 1989
3. TIME OF DEATH: 135 pm M
4. SOCIAL SECURITY NUMBER: 213 34 5502
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11 7 11
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Annapolis Convalescent Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annaplois
9c. COUNTY OF DEATH: Anne Arundel

**RESIDENCE OF DECEDENT**

10a. STATE: Maryland
10b. COUNTY: Calvert
10c. CITY, TOWN OR LOCATION: Prince Frederick
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3125 Dares Beach Road
10f. ZIP CODE: 20678
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): unknown — College (1-4 or 5+): unknown
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: homemaker
17. FATHER'S NAME (First, Middle, Last): Edward E. Hooper
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie Williams
19a. INFORMANT'S NAME (Type/Print): Eleanor V. Peake
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 Cedar Lane Edgewater Maryland 21037
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Asbury Methodist Cemetery
20c. LOCATION — City or Town, State: Barstow Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: BRausch
22. NAME AND ADDRESS OF FACILITY: Rausch Funeral Home, 4405 Broomes island Road Port Republic Md

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):
b. Cerebro Vascular Accident

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) — 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William R. Jones MD
29c. LICENSE NUMBER: D06054
29d. DATE SIGNED (Month, Day, Year): 10/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William R. Jones, MD 695 America Ct. 21035
31. DATE FILED (Month, Day, Year): OCT 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

5

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edward Robert Meserole | | | 2. DATE OF DEATH MONTH: 10 DAY: 16 YEAR: 89 | 3. TIME OF DEATH: 9:15 P M |
| 4. SOCIAL SECURITY NUMBER: 152-18-1408 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 04-20-26 | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: N.J. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Jersey City | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 212 Bartholdi Ave. | 10f. ZIP CODE: 07305 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Type Setter | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Edward Meserole | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Viola | |
| 19a. INFORMANT'S NAME (Type/Print): Richard Meserole | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Grovenor Rd Jamacia Plain Ma 02130 | |
| 20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rosehill Crematory | 20c. LOCATION — City or Town, State: Linden N J | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul J Wallbrun | | 22. NAME AND ADDRESS OF FACILITY: 12 Ridgley Ave Annapolis Md 21401 Hardesty Funeral Home | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CLL

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. perforation of stomach

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Paul J Wallbrun | 29c. LICENSE NUMBER: D0 8118 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY WATKINS JR MD 51 FRANKLIN ST ANNAPOLIS MD 21401

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 18 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|
| MARGARET C. MARTINI | Oct. 21, 1989 | P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 116-22-1734 | 1 ☐ M 2 ☒ F | 85 YRS. | | | Sept. 25, 1904 | California |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Annapolis Convalescent Center | Annapolis | Anne Arundel |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Annapolis | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 4 Southgate Court | 21401 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Homemaker | Home |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Patrick W. Curtin | Blossom Seely |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Philip J. Martini | 4 Southgate Court, Annapolis, MD 21401 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Long Island National Cem. | N. York Farmingdale, L.I. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Donald A. Seyfert | Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): | 2-3 wks |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| R. Hochman, MD | D5192 | ▶ 10/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Richard I. Hochman, MD - 16 Murray Ave, Annapolis, Md 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 24 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

2

(B)

89 29923

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): PATRICIA ANN MARTYN | | | 2. DATE OF DEATH (Month, Day, Year): 10 17 89 | 3. TIME OF DEATH: 0148 PM M |
| 4. SOCIAL SECURITY NUMBER: 099-22-0147 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12-13-28 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | 9c. COUNTY OF DEATH: A.A. COUNTY |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 628 Whittier Pa | | 10f. ZIP CODE: 21146 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: MD State Police Department |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Michael Kirk | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Follis |
| 19a. INFORMANT'S NAME (Type/Print): Patrick Martyn | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 628 Whittier Parkwaay Severna Park, MD 21146 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Charles Cemetery | 20c. LOCATION — City or Town, State: Farmingdale, L.I. N.Y. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E. Barranco | 22. NAME AND ADDRESS OF FACILITY: Barranco & Sons Severna Park Funeral Home Maryland 21146 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intra Cranial Hemorrhage

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Chakumkal V. Cyriac MD Private Doctor | 29c. LICENSE NUMBER: D21684 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-18-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHACKUMKAL V. CYRIAC, M.D. 14 WELLHAM AVENUE, SUITE 101 GLEN BURNIE, MARYLAND 21 | | |
| 31. DATE FILED (Month, Day, Year): OCT 25 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Rendell | |

OHMH-16 Rev 1/89

10

89 29924

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARGARET ELIZABET MCGOWAN | | 2. DATE OF DEATH (Month, Day, Year): 10 28 89 | 3. TIME OF DEATH: 1200 AM M |
| 4. SOCIAL SECURITY NUMBER: 219-30-1950 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): May 1, 1910 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | 9c. COUNTY OF DEATH: A.A. COUNTY | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Severna Park | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 819 Manhattan Beach Rd. | 10f. ZIP CODE: 21146 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Hospital | |
| 17. FATHER'S NAME (First, Middle, Last): John Beck | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Josephine Schaefer | | |
| 19a. INFORMANT'S NAME (Type/Print): James F. McGowan | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 819 Manhattan Beach Rd., Severna Park, MD 21146 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park | 20c. LOCATION — City or Town, State: Dorsey, Howard, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, MD 21061 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio respiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] date | 29c. LICENSE NUMBER: D23824 | 29d. DATE SIGNED (Month, Day, Year): 10/29/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BASANT K. KHANDELWAL, M.D. 7422 BALTIMORE-ANNAPOLIS BLVD GLEN BURNIE, MARYLAND | | |
| 31. DATE FILED (Month, Day, Year): OCT 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

89 29925

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

6

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) DAVID R. NORCROSS / David R. Norcross | | | | 2. DATE OF DEATH MONTH 10 DAY 14 YEAR 89 | 3. TIME OF DEATH 1325 M |
| 4. SOCIAL SECURITY NUMBER 217-28-1939 | 5. SEX 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday) 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4-16-25 | 8. BIRTHPLACE (State or Foreign Country) Wash., D.C. |
| 9a. FACILITY NAME (If not institution, give street and number) Anne Arundel General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | | 9c. COUNTY OF DEATH Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE MD | 10b. COUNTY Montgomery | 10c. CITY, TOWN OR LOCATION Bethesda | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER 5327 Allandale Road | | 10f. ZIP CODE 20816 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES WW II, Korea | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Consultant | 16b. KIND OF BUSINESS/INDUSTRY Building Construction Ind. |
| 17. FATHER'S NAME (First, Middle, Last) Theodore W. Norcross | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Christine Cleveland | |
| 19a. INFORMANT'S NAME (Type/Print) Shirley Norcross | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5327 Allandale Rd., Bethesda, MD 20816 | |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Comfort Crematory | 20c. LOCATION — City or Town, State Alexandria, VA |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Mike Nelson | | 22. NAME AND ADDRESS OF FACILITY 3630 Wis. Ave. NW Washington, DC 20016 Jos. Gawler's Sons, Inc. | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ACUTE Coronary CORONARY Insufficiency INSUFFICIENCY | SECONDS |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES XX NO | 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ✓ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER 033757 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10-14-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 108 ASHEWTON ROAD SEVERNA PARK MD | | |
| 31. DATE FILED (Month, Day, Year) OCT 18 '89 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 29926

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): VIRGINIA ELGIN PARK
2. DATE OF DEATH — MONTH: 10 DAY: 17 YEAR: 89
3. TIME OF DEATH: 20:26 PM
4. SOCIAL SECURITY NUMBER: 579-12-2867
5. SEX: 1 ☐ M 2 ☒ F
5. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1920
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Riva
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3036 Pike Drive
10f. ZIP CODE: 21140
10g. CITIZEN OF WHAT COUNTRY?: U..S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Thrift B. Elgin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Smith
19a. INFORMANT'S NAME (Type/Print): Harold George Park, Jr.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3036 Pike Drive, Riva, Maryland 21140
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln
20c. LOCATION — City or Town, State: Brentwood, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEAD AND NECK CARCINOMA - INVASIVE — MONTHS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. TOBACCO AND ALCOHOL ABUSE

DUE TO (OR AS A CONSEQUENCE OF):

c. EMPHYSEMA

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD CHARLES SEAGRAM
29c. LICENSE NUMBER: D33757
29d. DATE SIGNED (Month, Day, Year): ▶ 10-17-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 269 PENINSULA FARM ROAD ARNOLD

31. DATE FILED (Month, Day, Year): OCT 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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6

89 29927

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1a. DECEDENT'S NAME (First, Middle, Last): DOROTHY J. ROGERS

2. DATE OF DEATH: MONTH 10 DAY 19 YEAR 89

3. TIME OF DEATH: 0150 AM M

4. SOCIAL SECURITY NUMBER: 013-24-8148

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 59 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 08 12 30

8. BIRTHPLACE (State or Foreign Country): MASSACHUSETTS

9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE

9c. COUNTY OF DEATH: A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: ANNE ARUNDEL

10c. CITY, TOWN OR LOCATION: GLEN BURNIE

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 115 COUNTRY CLUB DRIVE

10f. ZIP CODE: 21061

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): –

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETERY

16b. KIND OF BUSINESS/INDUSTRY: INSURANCE SALES

17. FATHER'S NAME (First, Middle, Last): CARL G. LINDAHL

16. MOTHER'S NAME (First, Middle, Maiden Surname): DOROTHY E. FOLEY

19a. INFORMANT'S NAME (Type/Print): BETTY J. NOLAND

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 COUNTRY CLUB DR. GLEN BURNIE, MD. 21061

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METRO CREMATORY, INC.

20c. LOCATION — City or Town, State: CATONSVILLE, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mary L. Kaufman

22. NAME AND ADDRESS OF FACILITY: RAYMOND C. FINK FUNERAL HOME 21061, 426 CRAIN HWY. S.W. GLEN BURNIE, MD.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-respiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. - massive G-Astro-Intestinal Bleeding

DUE TO (OR AS A CONSEQUENCE OF):

c. arrhosis of liver

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO — N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Manejwala M.D.

29c. LICENSE NUMBER: D29748

29d. DATE SIGNED (Month, Day, Year): ▶ 10/19/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27 (Type, Print): ALIF MANEJWALA, M.D. 1414 CRAIN HIGHWAY GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): OCT 20 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 29928

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn F. Robinson
2. DATE OF DEATH: MONTH 10 DAY 21 YEAR 89
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 108-09-8043
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 09-25-11
8. BIRTHPLACE (State or Foreign Country): Schnectady, NY
9a. FACILITY NAME (If not institution, give street and number): Chesapeake Manor Nurs, Home
9b. CITY, TOWN OR LOCATION OF DEATH: Arnold
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Davidsonville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 953 St. George Barker Road
10f. ZIP CODE: 21035
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Household
17. FATHER'S NAME (First, Middle, Last): George Finster
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Anne Williamson
19a. INFORMANT'S NAME (Type/Print): Nigel Robinson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 953 St. George Barker Rd. Davidsonville, MD
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Cemetery
20c. LOCATION — City or Town, State: Davidsonville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF): b. Congestive Heart Failure
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF): c.
DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Medical Director
29c. LICENSE NUMBER: D21684
29d. DATE SIGNED (Month, Day, Year): ▶ 10.23.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C.V. CYRUS M.D. 14 WELLHAM AVE N.W. GLENBURNIE, MD 21061
31. DATE FILED (Month, Day, Year): OCT 23 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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89 29929

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) John W. Skipper | | | | | 2. DATE OF DEATH Month: 10 Day: 14 Year: 89 | | 3. TIME OF DEATH 11:12 P M |
| 4. SOCIAL SECURITY NUMBER 419-34-0626 | 5. SEX 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday) 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) 09-28-30 | | 8. BIRTHPLACE (State or Foreign Country) Alabama |
| 9a. FACILITY NAME (If not institution, give street and number) Anne Arundel Medical Center | | | | | 9b. CITY, TOWN OR LOCATION OF DEATH Annapolis | | 9c. COUNTY OF DEATH Anne Arundel |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE MD | 10b. COUNTY Anne Arundel | | 10c. CITY, TOWN OR LOCATION Annapolis | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO |
| 10e. STREET AND NUMBER 875 Boatswain Way | | | | 10f. ZIP CODE 21401 | | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lieutenant | | 16b. KIND OF BUSINESS/INDUSTRY US Navy retired | | |
| 17. FATHER'S NAME (First, Middle, Last) Oscar William Skipper | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruby Lee Cook | | |
| 19a. INFORMANT'S NAME (Type/Print) Zelda Skipper | | | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 875 Boatswain Way, Annapolis, MD 21401 | | |
| 20a. METHOD OF DISPOSITION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery | | 20c. LOCATION — City or Town, State Arlington, VA | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Jackson W. Hardesty | | | | | 22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home 12 Ridgely Ave. Annapolis, MD 21401 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
b. cardiogenic shock
DUE TO (OR AS A CONSEQUENCE OF):
c. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER D15809

29d. DATE SIGNED (Month, Day, Year) ▶ Oct 17 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year) OCT 17 1989

32. REGISTRAR'S SIGNATURE Julia Davidson-Kendall

DHMH-16 Rev 1/89

89 29930

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should accompany the burial-transit permit.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Anita Rowland | | | 2. DATE OF DEATH (Month, Day, Year): 10-14-89 | 3. TIME OF DEATH: 5 ~~P~~ A M |
| 4. SOCIAL SECURITY NUMBER: 212-76-1267 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08-06-32 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): 158 Defense Highway | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 158 Defense Highway | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A | 16b. KIND OF BUSINESS/INDUSTRY |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Herbert M. Rowland | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Madeline Williams |
| 19a. INFORMANT'S NAME (Type/Print): Herbert M. Rowland | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 158 Defense Highway, Annapolis, MD |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Paul Hardesty | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Ave. Annapolis, MD 21401 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory arrest | shortest |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Dermis Squamous | life- |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☑ NO | 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: MD | 29c. LICENSE NUMBER: D05259 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 16 1989 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Kendall |

DHMH-16 Rev 1/89

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89 29931

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): John R. Shematz Jr. | | | | | 2. DATE OF DEATH (Month, Day, Year): 10 25 89 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 216-40-1266 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 47 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 08-14-42 | 8. BIRTHPLACE (State or Foreign Country): North Carolina |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO | |
| 10e. STREET AND NUMBER: 932 Barracuda Cove Court | | 10f. ZIP CODE: 21401 | | | 10g. CITIZEN OF WHAT COUNTRY? USA | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: Vietnam | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 5+ | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney | | | 16b. KIND OF BUSINESS/INDUSTRY: Law | |
| 17. FATHER'S NAME (First, Middle, Last): John R. Shematz Sr. | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Alvina Milasich | |
| 19a. INFORMANT'S NAME (Type/Print): Melinda M. Shematz | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 932 Barracuda Cove Court, Annapolis, MD | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory | | | 20c. LOCATION — City or Town, State: Baltimore, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Patrick J Arnold | | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgely Ave. Ann, MD 21401 | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. BRAIN ANOXIA | 10' |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CARDIO RESPIRATORY ARREST | 10' |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Extensive (R) Temporal Lobe Glioblastoma Multiforme | ~ 6 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CRANIOTOMY FOR (R) Temporal Mass and IC HTN | ~ 7 days |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

(IC HTN = Intracranial hypertension)

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 X NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 X NO | HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| MD | D31997 | ▶ 10/25/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 16 Murray Ave ANNAPOLIS Md 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 26 1989 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 29932

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 4 is the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for statistical purposes. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Myrtle W. Smith | | | | 2. DATE OF DEATH: MONTH 10 DAY 11 YEAR 89 | 3. TIME OF DEATH: 8 30 AM PM |
| 4. SOCIAL SECURITY NUMBER: 220-07-5461 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-11-05 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: A.A. |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: A.A. | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 1034 Spa Road Apt. C | | 10f. ZIP CODE: 21403 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautician | 16b. KIND OF BUSINESS/INDUSTRY: Beauty Parlor | |
| 17. FATHER'S NAME (First, Middle, Last): Earl Gordon Townshend, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Myrtle Winona Townshend | |
| 19a. INFORMANT'S NAME (Type/Print): Sandra Rivera | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1034 Spa Road, Apt. C., Annapolis, MD 21401 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan | 20c. LOCATION — City or Town, State: Alexandria, VA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald L. Ly | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 147 Gloucester St., Annapolis, MD 21401 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CANCER OF BREAST | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Stanley Watkins | D08818 | ▶ 10/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STANLEY I WATKINS MD 51 FRANKLIN ST ANN MD 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 16 1989 | Julia Davidson-Randall |

OHMH-16 Rev 1/89

2

89 29933

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): BLANCHE D SKAR | | 2. DATE OF DEATH (Month, Day, Year): 10/27/1989 | 3. TIME OF DEATH: 7A M |
| 4. SOCIAL SECURITY NUMBER: 234-96-2611 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10/06/07 |
| 8. BIRTHPLACE (State or Foreign Country): West Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 914 Bethany Court | 10f. ZIP CODE: 21403 | 10g. CITIZEN OF WHAT COUNTRY? U S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 8+): 1 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home |
| 17. FATHER'S NAME (First, Middle, Last): George Mazur | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada | |
| 19a. INFORMANT'S NAME (Type/Print): Dolores B. Skar | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 914 Bethany Court, Annapolis, MD 21403 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery | 20c. LOCATION — City or Town, State: Annapolis, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Respiratory Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Metastatic Colon Cance | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure
Post Cerebrovascular Accident
Hypertension

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D36488 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/27/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): OCT 30 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

3

89 29934

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SARAH B STOKES
2. DATE OF DEATH (Month, Day, Year): Oct. 18, 1989
3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 11, 1917
8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Annapolis
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2 N. Cherry Grove Avenue
10f. ZIP CODE: 21401
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Ezra Lord Bushnell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Salter
19a. INFORMANT'S NAME (Type/Print): Sally Parchman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 710 Americana Drive, Apt. 42, Annapolis, MD 21403
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan
20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jeffrey S. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO PULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. HASCVD

DUE TO (OR AS A CONSEQUENCE OF):

c. COPD

DUE TO (OR AS A CONSEQUENCE OF):

d. CA Breast

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J. Lapenta MD
29c. LICENSE NUMBER: D 21438
29d. DATE SIGNED (Month, Day, Year) ▶ 10/19/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LAPENTA 703 GIDDINGS AVE SEMI ANNAPOLIS MD 21401

31. DATE FILED (Month, Day, Year): OCT 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

5

SABINA SMITH

89 29935

B

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Sabina G. Smith | | | 2. DATE OF DEATH Month: 10 Day: 17 Year: 89 | 3. TIME OF DEATH: 6 PM M |
| 4. SOCIAL SECURITY NUMBER: 083-07-6275 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 11-16-12 | 8. BIRTHPLACE (State or Foreign Country): New York |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | | 9c. COUNTY OF DEATH: Anne Arundel |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 851 Boatswain Way | | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | 16b. KIND OF BUSINESS/INDUSTRY: Home | | |
| 17. FATHER'S NAME (First, Middle, Last): Water Goodwin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Theodora Carlson | | |
| 19a. INFORMANT'S NAME (Type/Print): Cynthia B. Parr | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 306 Queen Anne Road, Stevensville, MD 21666 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan | 20c. LOCATION — City or Town, State: Alexandria, VA | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. LYMPHOMA
DUE TO (OR AS A CONSEQUENCE OF):
b. RENAL FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | |
|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| | 28d. DESCRIBE HOW INJURY OCCURED | | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Stanley F. Wolkenstein | D08118 | ▶ 10/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S.F. WATKINS 51 FRANKLIN ST ANNAPOLIS MD 21401

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 24 1989 | Julia Davidson-Randall |

DNMN-16 Rev 1/89

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89 29936

B

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Kathleen Sharrocks | | | | | 2. DATE OF DEATH (Month, Day, Year): 10-22-1989 | 3. TIME OF DEATH: 6:12 P M |
| 4. SOCIAL SECURITY NUMBER: 168-32-1348 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-17-1900 | 8. BIRTHPLACE (State or Foreign Country): Pennslyvania |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Arnapolis | | 9c. COUNTY OF DEATH: Anne Arundel | |
| **RESIDENCE OF DECEDENT** | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 4908 Arabia Avenue | | 10f. ZIP CODE: 21214 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12+ / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker | | | 16b. KIND OF BUSINESS/INDUSTRY: HOME | |
| 17. FATHER'S NAME (First, Middle, Last): John William P. Seward | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine | |
| 19a. INFORMANT'S NAME (Type/Print): John E. Wall | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4908 Arabia Avenue Baltimore, MD 21214 | | | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Odd Fellows Cemetery | | | 20c. LOCATION — City or Town, State: Shanandoah Hieghts, PA | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James E. Barnes | | 22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Highway Severna Park, MD 21146 | | | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Cardiopulmonary arrest | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Acute cholecystitis | 2 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Cerebrovascular accidents, multiple | 3mo - 1day |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| M. M. Mullins, MD | | ▶ 10/23/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 25 1989 | Gina Lorraine Randall |

DHMH-18 Rev 1/89

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89 29937

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| MYRNA | ALICE | TAYLOR | 10 14 89 | 844 AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-32-5302 | 1 ☐ M 2 ☒ F | 52 YRS. | | | June 15, 1937 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| NORTH ARUNDEL HOSPITAL | GLEN BURNIE | A.A. COUNTY |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Anne Arundel | Severn | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 7769 Ricker Rd. | 21144 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Classified | Ft. Meade- Civilian Emp. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Ernest S. Taylor | Edith Willis |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| JoAnn McFee | 545D Tranquill Ct., Odenton, MD 21113 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Friendship Cemetery | Hanover, A.A., MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Kirkley Funeral Home 421 Crain Hwy S.E., Glen Burnie, MD 21061 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Acute myocardial infarction | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): b. Ischemic Heart Disease with | |
| | DUE TO (OR AS A CONSEQUENCE OF): c. Arrythmia | |
| | DUE TO (OR AS A CONSEQUENCE OF): d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Abnormal glucose tolerance

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Jose Presbitero, M.D. | D 16208 | ▶ 10/14/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DR. JOSE M., PRESBITERO M.D. 7845 OAKWOOD ROAD #107 GLEN BURNIE, MARYLAND 2106

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 16 1989 | Julie Davidson-Kindell |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be [illegible] the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29938

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use of the Bureau. Last permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edgar R. Watkins
2. DATE OF DEATH: MONTH 10 DAY 11 YEAR 89
3. TIME OF DEATH: 8:10 P M
4. SOCIAL SECURITY NUMBER: 705-09-0501
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 02-26-11
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Med. Ctr
9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis
9c. COUNTY OF DEATH: A.A

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Sherwood Forest
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 909 Ravenshead Hill
10f. ZIP CODE: 21405
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Transportation Job Corps
16b. KIND OF BUSINESS/INDUSTRY: Civil Service
17. FATHER'S NAME (First, Middle, Last): Russell Watkins
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Kirby
19a. INFORMANT'S NAME (Type/Print): Timothy E. Foley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1628 Feldbrook Road, Towson, MD 21204
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan
20c. LOCATION — City or Town, State: Alexandria, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Taylor
22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401, 147 Gloucester St., Annapolis, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c. Fx Rt hip
DUE TO (OR AS A CONSEQUENCE OF):
d. COPD

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jack Lichtenstein
29c. LICENSE NUMBER: D08194
29d. DATE SIGNED (Month, Day, Year): 10/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jack R. Lichtenstein, M.D., 207 Ridgely Ave., Annapolis, MD 21401
31. DATE FILED (Month, Day, Year): OCT 16 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson

DHMH-16 Rev 1/89

12

89 29939

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mildred Louise Walters | | 2. DATE OF DEATH (Month, Day, Year): 10- 13- 89 | 3. TIME OF DEATH: 12 noon M |
| 4. SOCIAL SECURITY NUMBER: 217-20-1076 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7. DATE OF BIRTH (Month, Day, Year): 07/10/26 | 8. BIRTHPLACE (State or Foreign Country): Glen Burnie, MD | | |
| 9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |
| **RESIDENCE OF DECEDENT** | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Queen Anne's | 10c. CITY, TOWN OR LOCATION: Chester | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Rt. 2 Box 733 | 10f. ZIP CODE: 21619 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker & Secretary | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Carson Gernert | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mildred Dorman | | |
| 19a. INFORMANT'S NAME (Type/Print): Raymond J. Walters | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 733, Chester, Maryland 21619 | | |
| 20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Woodlawn Memorial Park | 20c. LOCATION — City or Town, State: Easton, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas K. Helfenbein | 22. NAME AND ADDRESS OF FACILITY: Tom Helfenbein Funeral Homes, P.A. Chester, Maryland 21619 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Ventricular Fibrillation | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CHF | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabets | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. CAD | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| | | | |

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Gary J Sprouse MD | D32036 | ▶ 10/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PO Box 210 Queenstown, MD 21658 (Dr. Gary J. Sprouse)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 17 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

ITEMS:6,7 per FH G-659
1-4-90 cm

89 29940

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES GARDNER WOODWARD

2. DATE OF DEATH (Month, Day, Year): Oct. 21, 1989

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 900-01-3230

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): ~~87~~ 83 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): Aug. 31, ~~1902~~ 1906

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 705 Americana Drive, Apt. 21

9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis

9c. COUNTY OF DEATH: Anne Arundel

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Anne Arundel

10c. CITY, TOWN OR LOCATION: Annapolis

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 705 Americana Drive, Apt. 21

10f. ZIP CODE: 21403

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 6+): 5 +

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney

16b. KIND OF BUSINESS/INDUSTRY: Law

17. FATHER'S NAME (First, Middle, Last): William N. Woodward

18. MOTNER'S NAME (First, Middle, Maiden Surname): Jenny G. Ashwell

19a. INFORMANT'S NAME (Type/Print): Emily C. Woodward

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 705 Americana Drive, Apt. 21, Annapolis, MD 21403

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Anne's Cemetery

20c. LOCATION — City or Town, State: Annapolis, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald A. Leyton

22. NAME AND ADDRESS OF FACILITY: Taylor Funeral Chapel 21401
147 Gloucester St., Annapolis, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ASCVD

DUE TO (OR AS A CONSEQUENCE OF):

c. Diabetes Mellitus

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara T. Furlow

29c. LICENSE NUMBER: D-18809

29d. DATE SIGNED (Month, Day, Year): 10/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Barbara T. Furlow - 77 West Street, Annapolis, MD 21401

31. DATE FILED (Month, Day, Year): OCT 24 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

89 29941

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Henry K. Westphal

**2. DATE OF DEATH** (Month, Day, Year): 10-26-89

**3. TIME OF DEATH**: 0200 M

**4. SOCIAL SECURITY NUMBER**: 275-03-6763

**5. SEX**: 1 [X] M 2 [ ] F

**6. AGE** (In yrs. last birthday): 83 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 9-24-06

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): Anne Arundel Medical Center

**9b. CITY, TOWN OR LOCATION OF DEATH**: Annapolis

**9c. COUNTY OF DEATH**: Anne Arundel

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Anne Arundel

**10c. CITY, TOWN OR LOCATION**: Annapolis

**10d. INSIDE CITY LIMITS?**: 1 [ ] YES 2 [X] NO

**10e. STREET AND NUMBER**: 1814 Pleasant Plains Road

**10f. ZIP CODE**: 21401

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [ ] NO Specify:

**14. RACE** — American Indian, Black, White, etc.
Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Executive

**16b. KIND OF BUSINESS/INDUSTRY**: Nationwide Insurance Company

**17. FATHER'S NAME** (First, Middle, Last): William H. Westphal

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Maude Rawlings

**19a. INFORMANT'S NAME** (Type/Print): Elizabeth Woodburn

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1814 Pleasant Plains Road, Annapolis, MD 21401

**20a. METHOD OF DISPOSITION**: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): St. Margarets Cemetery

**20c. LOCATION** — City or Town, State: Annapolis, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: Donald A. Taylor

**22. NAME AND ADDRESS OF FACILITY**: Taylor Funeral Chapel 21401
147 Gloucester St., Annapolis, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio-Resp. Arrest.
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Coronary Artery Disease.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 [ ] YES 2 [X] NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 [ ] YES 2 [ ] NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 [ ] YES 2 [X] NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

**27. MANNER OF DEATH**: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 [ ] YES 2 [ ] NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: R Brimhall M.D.

**29c. LICENSE NUMBER**: D 01846

**29d. DATE SIGNED** (Month, Day, Year): ▶ 10/26/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): Rodney L. Brimhall, M.D. 1833-A Forest Drive, Annapolis, MD

**31. DATE FILED** (Month, Day, Year): OCT 30 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-15 Rev 1/89

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89 53471

89 29942

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): STANLEY B WARFIELD | | | | | 2. DATE OF DEATH: MONTH 10 DAY 27 YEAR 89 | 3. TIME OF DEATH: 1238 PM |
| 4. SOCIAL SECURITY NUMBER: 218-03-7100 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7/23/09 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): RESIDENCE OF DECEDENT NORTH ARUNDEL HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE | | | 9c. COUNTY OF DEATH: A.A. COUNTY |
| 10a. STATE: Maryland | 10b. COUNTY: Anne Arundel | | 10c. CITY, TOWN OR LOCATION: Severn | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 1308 Severn Station Rd. | | | 10f. ZIP CODE: 21144 | | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | | | 16b. KIND OF BUSINESS/INDUSTRY: Farming |
| 17. FATNER'S NAME (First, Middle, Last): Benjamin Warfield | | | 18. MOTHER'S NAME (First, Middle, Melden Surname): Ida V. Durm | | | |
| 19a. INFORMANT'S NAME (Type/Print): Iva G. Warfield | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1308 Severn Station Rd., Severn, MD 21144 | | | |
| 20a. METNOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetary, crematory or other place): Glen Haven Memorial Park | | | 20c. LOCATION — City or Town, State: Glen Burnie, A.A., MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | | | 22. NAME AND ADDRESS OF FACILITY: Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, MD 21061 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Acute Cardiac Arrhythmia
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Abdominal Aortic Aneurysm
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |
|---|---|

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| William P. Jones MD Deputy | D 06054 | ▶ 10/27/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William P. Jones, MD 695 America 21035
~~JONATHAN K. SINGAL 7422 BALTIMORE ANNAPOLIS BLVD. GLEN BURNIE, MD. 21061~~

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 30 1989 | Julia Davidson-Rendell |

DHMH-16 Rev 1/89

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89 29943

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Michael Joseph Yanulis | | | 2. DATE OF DEATH (Month, Day, Year): 10/16/89 | 3. TIME OF DEATH: 9:00p M |
| 4. SOCIAL SECURITY NUMBER: 149-12-7831 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 07/03/25 | 8. BIRTHPLACE (State or Foreign Country): NJ |
| 9a. FACILITY NAME (If not institution, give street and number): Annapolis Conv. Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis | 9c. COUNTY OF DEATH: Anne Arundel | |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Arnold | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO | |
| 10e. STREET AND NUMBER: 1462 Bay Green Drive | | 10f. ZIP CODE: 21012 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 06/04/43 - 03/19/46 | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plastics Engineer | 16b. KIND OF BUSINESS/INDUSTRY: State of Maryland | |
| 17. FATHER'S NAME (First, Middle, Last): Michael Yanulis | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Tekla Unknown | | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Sheila A. Yanulis | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1462 Bay Green Drive Arnold MD 21012 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans | 20c. LOCATION — City or Town, State: Crownsville, MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert S. Barranco | | 22. NAME AND ADDRESS OF FACILITY: 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Overwhelming Infection | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Lung Cancer | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PARKINSON'S

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: MD 36488

29d. DATE SIGNED (Month, Day, Year): ▶ 10/17/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): OCT 25 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

5

89 29944

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Louise Butler
2. DATE OF DEATH (Month, Day, Year): Oct. 15, 1989
3. TIME OF DEATH: 11 a.m. M
4. SOCIAL SECURITY NUMBER: 217-01-9179
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): July 29, 1899
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Chapel Hill Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Reisterstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 456 Main St.
10f. ZIP CODE: 21136
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Saleslady
16b. KIND OF BUSINESS/INDUSTRY: Dept. Store
17. FATHER'S NAME (First, Middle, Last): John Butler
16. MOTHER'S NAME (First, Middle, Maiden Surname): Carolina Jones
19a. INFORMANT'S NAME (Type/Print): Joyce Stansfield
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Geroed Ave., Reisterstown, Md. 21136
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery
20c. LOCATION — City or Town, State: Pikesville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: H. J. Eckhardt
22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, 11605 Reisterstown Rd., Owings Mills, Md. 21117

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia; Osteoporosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D27123
29d. DATE SIGNED (Month, Day, Year): ▶ 10/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Judith Minkove 11E, Chestnut Hill Ln. Reisterstown MD 21136
31. DATE FILED (Month, Day, Year): OCT 17 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29945

6

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| LOUIS | CLARK | 10 / 15 / 89 | 5:50P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-30-0216 | 1 XX M 2 ☐ F | 84 YRS. | | | 9-26-1905 | MD. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| St. Joseph Hospital | Towson | Baltimore |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore | Lutherville | 1 ☐ YES 2 XX NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 11152 Falls Road | 21093 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced | 1 X YES 2 ☐ NO WWII 1943-46 | 1 ☐ YES 2 X NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | TEACHER | St. Pauls School |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Louis Thomas Clark | Desiree Branch |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Helen Clark | 11152 Falls Road Lutherville, Maryland 21093 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | St Johns Cemetery | Ellicott City, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ John Callan Slack MOD 535 | SLACK FUNERAL HOME PO BOX 268 E.C. 21043 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CARDIO-PULMONARY INSUFFICIENCY

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. AGE (82)

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

LONG STANDING HYPERTENSION

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 X NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) TENNIS COURT |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | NA | M | 1 ☐ YES 2 ☐ NO | |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| | |

29a. CERTIFIER (Check only one)

1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | 014318 | ▶ 10/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ROBERT W. LISLE MD 57 W. Timonium Road Lutherville, Maryland 21093

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 18 '89 | Lisha Davidson-Randall |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 25 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

15

89 2442

89 29946

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): SHERISE RENEE COWAN

**2. DATE OF DEATH** Month: 10 Day: 09 Year: 89

**3. TIME OF DEATH**: 11:40 AM

**4. SOCIAL SECURITY NUMBER**:

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday) YRS.: IF UNDER 1 YEAR — MONTHS: DAYS: 2; IF UNDER 24 HRS. — HOURS: MIN.:

**7. DATE OF BIRTH** (Month, Day, Year): 10 07 89

**8. BIRTHPLACE** (State or Foreign Country): BALTIMORE

**9a. FACILITY NAME** (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD

**10b. COUNTY**: BALTIMORE

**10c. CITY, TOWN OR LOCATION**: TOWSON

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 1914 Crestview Road

**10f. ZIP CODE**: 21239

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS** 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: B

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): N/A
College (1-4 or 5+): N/A

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): N/A

**16b. KIND OF BUSINESS/INDUSTRY**: N/A

**17. FATHER'S NAME** (First, Middle, Last):

**18. MOTHER'S NAME** (First, Middle, Maiden Surname):

**19a. INFORMANT'S NAME** (Type/Print):

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code):

**20a. METHOD OF DISPOSITION** 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Greater BAltimore Med Ctr

**20c. LOCATION — City or Town, State**: To wson MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ R Bretzender

**22. NAME AND ADDRESS OF FACILITY**: GBMC 6701 N. Charles St. Balt MD 21204

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART i.** Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. EXTREME PREMATURITY
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. RENAL FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
c. INTRAVENTRICULAR HEMORRHAGE
DUE TO (OR AS A CONSEQUENCE OF):
d.

**PART ii.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH** 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: Rudolph Foy MD

**29c. LICENSE NUMBER**: D-22434

**29d. DATE SIGNED** (Month, Day, Year): ▶ 12-10-89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): RUDOLPH FOY, M.D. GBMC 6701 NORTH CHARLES ST. TOWSON, MD. 21204

**31. DATE FILED** (Month, Day, Year): OCT 11 1989

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 29947

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): James Frank Gibson

**2. DATE OF DEATH** (Month, Day, Year): 10 - 13 - 89

**3. TIME OF DEATH**: M

**4. SOCIAL SECURITY NUMBER**: 216-09-8883

**5. SEX**: 1 ☐ M 2 ☐ F

**6. AGE** (In yrs. last birthday): 89 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 06-11-00

**8. BIRTHPLACE** (State or Foreign Country): Maryland

**9a. FACILITY NAME** (If not institution, give street and number): 10310 Liberty Road

**9b. CITY, TOWN OR LOCATION OF DEATH**: Randallstown

**9c. COUNTY OF DEATH**: Baltimore

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Baltimore County

**10c. CITY, TOWN OR LOCATION**: Randallstown

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 10310 Liberty Road

**10f. ZIP CODE**: 21133

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): 5
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Supervisor

**16b. KIND OF BUSINESS/INDUSTRY**: Baltimore Gas & Electric

**17. FATHER'S NAME** (First, Middle, Last):

**18. MOTHER'S NAME** (First, Middle, Maiden Surname):

**19a. INFORMANT'S NAME** (Type/Print): Michael J. Gibson

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10312 Liberty Road Randallstown, MD 21133

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Lake View Cemetery

**20c. LOCATION — City or Town, State**: Sykesville, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Brian L. Haight

**22. NAME AND ADDRESS OF FACILITY**: HAIGHT FUNERAL HOME (P.O. BOX 195) Sykesville, MD 21784 (301)-795-1400

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications thet caused the death. Do not enter the mode of dying, such ea cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line.**

Approximate Interval Between Onset and Death

**IMMEDIATE CAUSE (Finel disease or condition resulting in death)** →
a. Myocardial Infarction — DUE TO (OR AS A CONSEQUENCE OF):
b. Angina — DUE TO (OR AS A CONSEQUENCE OF):

**Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST**
c. _____ DUE TO (OR AS A CONSEQUENCE OF):
d. _____

**PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☐ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY**: M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature]

**29c. LICENSE NUMBER**: D8029

**29d. DATE SIGNED** (Month, Day, Year): ▶ 10/14/89.

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)

**31. DATE FILED** (Month, Day, Year): OCT 18 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-15 Rev 1/89

89 29948

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Jeffrey | H | HAMILTON | October 4, 1989 | 11:02 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-80-9591 | 1 ☒ M 2 ☐ F | 28 YRS. | | | 3/12/1961 | MD |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Franklin Square Hospital | Baltimore | Baltimore |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Cecil | North East | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 101 Wallace Ave. | 21901 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 1 | Clerk | Acme Market |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John H. Hamilton Jr. | Margaret Johnson |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mary Etta Hamilton | 101 Wallace Ave., North East, MD 21901 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | North East Methodist | North East, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Robert J. Crouch | Crouch Funeral Home<br>127 S. Main St., North East, MD 21901 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Probable Septic Shock | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Immuno Suppressed with Overwhelming Sepsis | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Chemotherapy | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. Stage IV Hodgkins Disease | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☐ NO | HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| K. Raghavan | D36499 | ▶ 10-4-89 |

| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
|---|---|---|
| K. RAGHAVAN | M.D. | 9000 Franklin Square Dr., 21237 |

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 6 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

(12)

89 29949

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): HARRY J. KEEFE | | 2. DATE OF DEATH (Month, Day, Year): 10-20-89 | 3. TIME OF DEATH: 2:12 AM |
| 4. SOCIAL SECURITY NUMBER: 339-18-4073 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 8/6/28 |
| 8. BIRTHPLACE (State or Foreign Country): ILLINOIS | | | |
| 9a. FACILITY NAME (If not institution, give street and number): STELLA MARIS HOSPICE | 9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON, MD | 9c. COUNTY OF DEATH: BALTO CO, | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Towson | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7 Drake Court | | 10f. ZIP CODE: 21204 | 10g. CITIZEN OF WHAT COUNTRY?: U. S. A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager | 16b. KIND OF BUSINESS/INDUSTRY: Glass |
| 17. FATHER'S NAME (First, Middle, Last): Harry Keefe | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Cusack | |
| 19a. INFORMANT'S NAME (Type/Print): Kim Keefe | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 Drake Court Towson, Maryland 21204 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): South West Cemetery | 20c. LOCATION — City or Town, State: Collinsville, Connecticut |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Marzullo | | 22. NAME AND ADDRESS OF FACILITY: Marzullo Funeral Service 3981 Carrollton Road Upperco, Maryland 21155 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Pneumonia | 1 month. |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF): | Small Cell lung Carcinoma | 1 year |
| c. DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Brain metastases

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: J. Bourne MD | 29c. LICENSE NUMBER: 033624 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/20/89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | |
| 31. DATE FILED (Month, Day, Year): OCT 23 89 | 32. REGISTRAR'S SIGNATURE: Jean Davidson-Randall | |

OHMH-16 Rev 1/89

Item 6 10-26-89 Film G656 W.H. Per F/H

89 29950

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Miriam Kobre | | | 2. DATE OF DEATH (Month, Day, Year): 10 2 89 | 3. TIME OF DEATH: 4:05 PM |
| 4. SOCIAL SECURITY NUMBER: 577-03-4265B | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): ~~86~~ 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 6 20 02 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |
| RESIDENCE OF DECEDENT: | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Pikesville | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7920 Scotts Level Rd. | | 10f. ZIP CODE: 21208 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | | 16b. KIND OF BUSINESS/INDUSTRY: Domestic |
| 17. FATHER'S NAME (First, Middle, Last): Samuel Golaner | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Shapiro | | |
| 19a. INFORMANT'S NAME (Type/Print): Arnold Blaustein | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6606 Park Heights Ave. Baltimore, MD 21215 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bnai Israel Cemetery | | 20c. LOCATION — City or Town, State: Baltimore, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Margulis | | 22. NAME AND ADDRESS OF FACILITY: Hebrew Memorial Funeral Home, Inc. 1100 Reisterstown Rd., Balt. MD | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardiopulmonary Failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Aspiration Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Edward P. Trunk | D34951 | ▶ 10/2/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward P. Trunk Balt Co. General Hosp. Md

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 10 '89 | Jetta Davidson-Randall |

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29951

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ALTON G. MORGAN | | | | 2. DATE OF DEATH (Month, Day, Year): 10 22 89 | 3. TIME OF DEATH: 2150 M |
| 4. SOCIAL SECURITY NUMBER: 214-36-7369 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 50 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 07-03-39 | 8. BIRTHPLACE (State or Foreign Country): Washington, DC |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore County |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Randallstown | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 8812 Flagstone Drive | | 10f. ZIP CODE: 21133 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Estimator | 16b. KIND OF BUSINESS/INDUSTRY: Construction |
| 17. FATHER'S NAME (First, Middle, Last): Alton Glenn Morgan, Sr. | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Ila Nelson Morgan | |
| 19a. INFORMANT'S NAME (Type/Print): Joan B. Morgan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8812 Flagstone Drive Randallstown, MD 21133 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Washington, D.C. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian K. Haight | | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) Sykesville, Maryland 21784 (301)-795-1400 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HEPATO RENAL FAILURE | 0 MIN |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ETOH ABUSE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: OSTEOMYELITIS

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: C. Rani MD | 29c. LICENSE NUMBER: D37333 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10.22.89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C. RANI MD, BCGH, RANDALL | | |
| 31. DATE FILED (Month, Day, Year): OCT 24 '89 | 32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall | |

DHMH-18 Rev 1/89

89 29952

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Caroline Claire Otto | | 2. DATE OF DEATH (Month, Day, Year): Oct. 13, 1989 | 3. TIME OF DEATH: 8:45 A M |
| 4. SOCIAL SECURITY NUMBER: 214-12-8390 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/13/96 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Cherrywood Manor Nursing Home | 9b. CITY, TOWN OR LOCATION OF DEATH: Reisterstown | 9c. COUNTY OF DEATH: Baltimore | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: 406 Shirley Manor Rd., Reisterstown | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 406 Shirley Manor Rd. | 10f. ZIP CODE: 21136 | 10g. CITIZEN OF WHAT COUNTRY?: USA. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 6+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Statistical Clerk | 16b. KIND OF BUSINESS/INDUSTRY: Railroad | |
| 17. FATHER'S NAME (First, Middle, Last): John Butler | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Carolina Jones | | |
| 19a. INFORMANT'S NAME (Type/Print): Joyce Stansfield | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 Geroed Ave., Reisterstown, Md. 21136 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Druid Ridge Cemetery | 20c. LOCATION — City or Town, State: Pikesville, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. Eckhardt | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, Owings Mills, Md. 21117 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Atherosclerotic vascular disease — DUE TO (OR AS A CONSEQUENCE OF): — Months

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Cerebrovascular disease — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER: D27123 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/13/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 11E - Chestnut Hill Ln Reisterstown MD 21136 | | |
| 31. DATE FILED (Month, Day, Year): OCT 13 89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 29953

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 1429

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Katharine M. Stokes | | | 2. DATE OF DEATH (Month, Day, Year): 10 21 89 | 3. TIME OF DEATH: 1429 M |
| 4. SOCIAL SECURITY NUMBER: 384-38-2166 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 11-26-06 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Carroll County | 10c. CITY, TOWN OR LOCATION: Sykesville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 7200 Third Avenue | | 10f. ZIP CODE: 21784 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian | 16b. KIND OF BUSINESS/INDUSTRY: Bookkeeping |
| 17. FATHER'S NAME (First, Middle, Last): Charles S. Stokes | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Georgia Martin | |
| 19a. INFORMANT'S NAME (Type/Print): Mrs. Robert T. Oliver | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Byford Court Chestertown, MD 21620 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation Serv. | 20c. LOCATION — City or Town, State: Hampstead, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian K. Haight | | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) Sykesville, Maryland 21784 (301)-795-1400 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial infarction | immediate |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertension
depression/anxiety

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7200 Third Ave, Sykesville, MD 21784 | | |
| 31. DATE FILED (Month, Day, Year): OCT 24 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 29954

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RICHARD A. SHROAT | | | | | 2. DATE OF DEATH (Month, Day, Year): 4 7 89 | 3. TIME OF DEATH: 11:20 a M |
| 4. SOCIAL SECURITY NUMBER: 213-09-1122 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 4-7-11 | 8. BIRTHPLACE (State or Foreign Country): Pennsylvania |
| 9a. FACILITY NAME (If not institution, give street and number): Broademeade Retirement Center | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Cockeysville | | | 9c. COUNTY OF DEATH: Baltimore |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Cockeysville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 13801 York Road | | 10f. ZIP CODE: 21030 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5 +) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
| | | |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): HARRY EDWIN SHROAT | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CAROLYN DIETZ |
| 19a. INFORMANT'S NAME (Type/Print): Mrs Lucretia Shroat (spouse) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Sames as #10 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
| 21. SIGNATURE OF FUHERAL SERVICE LICENSEE ▶ | 22. NAME AND ADDRESS OF FACILITY: State Anatomy Board Baltimore, Md. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cardio Respiratory Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. ASCVD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Robert H. Wiedefeld, M.D. | 29c. LICENSE NUMBER: D33011 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert H. Wiedefeld MD

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 24 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 2995#

Robert H. Wiederich, M.D.

D3301

10-13-89

89 29955

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles A. Titcomb
2. DATE OF DEATH (Month, Day, Year): 10 22 89
3. TIME OF DEATH: 0834 M
4. SOCIAL SECURITY NUMBER: 214-01-8500
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 08/13/03
8. BIRTHPLACE (State or Foreign Country): MASS.
9a. FACILITY NAME (If not institution, give street and number): BALTIMORE COUNTY GENERAL HOSP
9b. CITY, TOWN OR LOCATION OF DEATH: RANDALLSTOWN
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CARROLL
10c. CITY, TOWN OR LOCATION: SYKESVILLE
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 6632 MONROE AVE
10f. ZIP CODE: 21784
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): High School; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SALES REP.
16b. KIND OF BUSINESS/INDUSTRY: SHELL OIL
17. FATHER'S NAME (First, Middle, Last): TITCOMB
18. MOTHER'S NAME (First, Middle, Maiden Surname): ELNA FOUNTAIN
19a. INFORMANT'S NAME (Type/Print): ANN T. DAVIS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6632 MONROE AVE SYKESVILLE, MD. 21784
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CARROLL CREMATION
20c. LOCATION — City or Town, State: HAMPSTEAD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight
22. NAME AND ADDRESS OF FACILITY: HAIGHT F.H. Box 195 Sykesville, MD 21784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYOCARDIAL INFARCTION — Approximate Interval: IMMED
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [X] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Susan Owens MD
29c. LICENSE NUMBER: D22751
29d. DATE SIGNED (Month, Day, Year): ▶ 10-22-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): OCT 24 '89
32. REGISTRAR'S SIGNATURE: Gina Davidson-Handelsman

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

- Cleared by M.E. dr Feldenkreuz -

89 29956

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna E. Wilson

2. DATE OF DEATH (Month, Day, Year): 10-17-1989

3. TIME OF DEATH: 12:47p M

4. SOCIAL SECURITY NUMBER: 216-14-4052

5. SEX: 1 ☐ M 2 ☑ F

6. AGE (In yrs. last birthday): 97 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 12-12-1891

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown

9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Baltimore

10c. CITY, TOWN OR LOCATION: Garrison

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 12 Montrose Ave.

10f. ZIP CODE: 21055

10g. CITIZEN OF WHAT COUNTRY?: USA.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 8+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): James Arthur Wilson

18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosalia Gover

19a. INFORMANT'S NAME (Type/Print): Mrs. Ethel Martz

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4207 York Rd. #1, Millers, Md. 21107

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pine Grove Cemetery

20c. LOCATION — City or Town, State: Middletown, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Larry Nuttle

22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel, Owings Mills, Md. 21117

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Gram negative UTI.

DUE TO (OR AS A CONSEQUENCE OF):

c. Gram positive Bacteremia

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Allan J. Chirgus M.D.

29c. LICENSE NUMBER: D29085

29d. DATE SIGNED (Month, Day, Year): ▶ 10-17-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allan J. Chirgus M.D. Baltimore County General Hospital

31. DATE FILED (Month, Day, Year): OCT 20 89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29957

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Raymond YOUNG | | | 2. DATE OF DEATH (Month, Day, Year): 10-7-89 | 3. TIME OF DEATH: 1100P M |
| 4. SOCIAL SECURITY NUMBER: 214-20-7365 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 06-02-23 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown | 9c. COUNTY OF DEATH: Baltimore | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore County | 10c. CITY, TOWN OR LOCATION: Baltimore | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 7445 Lexham Court | | 10f. ZIP CODE: 21207 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Black |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 8+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY: Johns Hopkins | |
| 17. FATHER'S NAME (First, Middle, Last): Benjamin Young | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Nettie Dorsey | |
| 19a. INFORMANT'S NAME (Type/Print): Mary H. Young | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7445 Lexham Court Baltimore, MD 21207 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bushy Park Cemetery | 20c. LOCATION — City or Town, State: Cooksville, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian L. Haight | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) SYKESVILLE, MD 21784 (301)-795-1400 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cerebral Vascular Thrombosis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Hypertension | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Diabetes Mellitus | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Sie K. Ong MD House physician | 29c. LICENSE NUMBER: D36456 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/7/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sie Kiem Ong MD, Baltimore County General Hospital, Randallstown, MD 21133 | | | |
| 31. DATE FILED (Month, Day, Year): OCT 13 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

UNKNOWN 89-183

89 29958

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month / Day / Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| Tyler | IAN | Anders | 10-7-89 | 7:47AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 446-88-9152 | 1 [X] M 2 [ ] F | 18 YRS. | | | MARCH 8,1971 | KANSAS |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| UNIT BLOCK OF W. LEXINGTON STREET | BALTIMORE CITY | BALTIMORE |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| OK. | COMANCHE | LAWTON | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 127 CIMERRON TRAIL | 73507 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO — ACTIVE DUTY | 1 [ ] YES 2 [X] NO Specify: | Specify: WHITE |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | E-1 ENLISTED, NAVY | DEFENSE |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| WILLIAM TYLER ANDERS | KAROLYN SCOTT |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| WILLIAM T. ANDERS | SAME AS ITEM #10 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | SUNSET MEMORIAL GARDENS | LAWTON , OK. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ W. W. Chambers MO0091 | W. W. CHAMBERS CO. , RIVERDALE, MD.20737 |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. GUNSHOT WOUND OF HEAD | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX 1 [X] YES 2 [ ] NO | XXX 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XXX YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 XX Other (Specify) SCENE |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 10-7-89 | M | 1 [ ] YES 2 [ ] NO | SUBJECT SHOT |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| STREET | UNIT BLOCK OF W. LEXINGTON ST. BALTIMORE CITY, MD |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle Jr MD | OCME | ▶ 10-7-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MARIO F. GOLLE, JR.MD 111 PENN STREET,BALTIMORE,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 12'89 | Jisha Davidson-Randall |

OHMH-16 Rev 1/89

10+1

89 29959

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Donald E Basham (Donald Earl Basham) | | | 2. DATE OF DEATH (Month, Day, Year): 9 28 1989 | 3. TIME OF DEATH: 10 57 AM |
| 4. SOCIAL SECURITY NUMBER: 407 28 3065 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 10/2/27 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital of Baltimore | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD | 9c. COUNTY OF DEATH: Balto- City | | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Harford | 10c. CITY, TOWN OR LOCATION: Belair | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: 605 Beretta Way | 10f. ZIP CODE: 21014 | 10g. CITIZEN OF WHAT COUNTRY? USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Parole Probation Officer | 16b. KIND OF BUSINESS/INDUSTRY: State of Maryland |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Milton Basham | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Claudia Woosley |
| 19a. INFORMANT'S NAME (Type/Print): Ariel E. Basham | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 605 Beretta Way, Bel Air, Md. 21014 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: ~~1 Burial~~ 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): R. A. Ferris Crematory ~~Centre U. Methodist Cemetery~~ | 20c. LOCATION (City or Town, State): West Chester, Pa. ~~Forest Hill, Md.~~ |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III | 22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Septic Shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Endocarditis

DUE TO (OR AS A CONSEQUENCE OF):

c. ~~Coronary Disease~~ Error

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Weinberg MD PhD Jr Asst Resident | 29c. LICENSE NUMBER: 9312 | 29d. DATE SIGNED (Month, Day, Year): 9/28/89 | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Irving Weinberg MD PhD, Sinai Hosp of Baltimore Dept of Medicine | | | |
| 31. DATE FILED (Month, Day, Year): SEP 29 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

89 29960

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DENNIS A. BOYLAND | | | 2. DATE OF DEATH (Month, Day, Year): 10 17 89 | 3. TIME OF DEATH: 3 15 AM |
| 4. SOCIAL SECURITY NUMBER: 579-16-5787 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): FEB. 22, 1920 | 8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC |
| 9a. FACILITY NAME (If not institution, give street and number): MERCY HOSPITAL | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE | | 9c. COUNTY OF DEATH: BALTIMORE CITY |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: FREDERICK | 10c. CITY, TOWN OR LOCATION: MONROVIA | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 4975 LINGANORE WOODS | | 10f. ZIP CODE: 21770 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+): 3 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ACCOUNTANT | 16b. KIND OF BUSINESS/INDUSTRY: CONSTRUCTION COMPANY |
| 17. FATHER'S NAME (First, Middle, Last): JOHN EDGAR BOYLAND | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY AGNES YOUNG | |
| 19a. INFORMANT'S NAME (Type/Print): RUTH A. BOYLAND | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4975 LINGANORE WOODS, MONROVIA, MARYLAND 21770 | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY | 20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J Bagley | | 22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Sepsis | hours |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Pneumonia | 2 days |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes, ASCVD

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO |
| 28d. DESCRIBE HOW INJURY OCCURED | | | |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: David Schaul MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): 10/17/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mercy Hospital 301 St. Paul Place Balt. MD 21202 | | |
| 31. DATE FILED (Month, Day, Year): OCT 19 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randolph | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

124

89 29961

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): CARLTON L CAMPBELL | | | | | 2. DATE OF DEATH (Month, Day, Year): AUGUST 18, 1989 | 3. TIME OF DEATH: 6:07 A M |
| 4. SOCIAL SECURITY NUMBER: 229-28-3587 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct/21/28 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: ANNE ARUNDEL | 10c. CITY, TOWN OR LOCATION: CROFTON | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: 1572 EATON WAY | | 10f. ZIP CODE: 21114 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): supermarket owner | 16b. KIND OF BUSINESS/INDUSTRY: grocery | |
| 17. FATHER'S NAME (First, Middle, Last): William E. Campbell | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lola Bryant | |
| 19a. INFORMANT'S NAME (Type/Print): Evi Campbell | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1572 Eaton Way Crofton Md 21114 | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery | 20c. LOCATION — City or Town, State: Suitland Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Melanie Wilhelm | 22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home, Inc 4308 Suitland Road Suitland MD 20746 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sech line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. LIVER FAILURE | 2 WKS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. CIRRHOSIS POSTNECROTIC | 3 YRS |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. CHRONIC ACTIVE HEPATITIS B | ? |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAL FAILURE
GI (VARICEAL) BLEEDING

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Mark C. Rutchell, J., M.D. | 29c. LICENSE NUMBER: D 23832 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/11/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JOHNS HOPKINS SCH OF MEDICINE, 725 N. WOLFE ST, BALTIMORE 21205

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 18 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson Randall |

DHMH-16 Rev 1/89

89 2991

89 29962

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

(R)

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY CARLISLE | | | 2. DATE OF DEATH (Month, Day, Year): OCT. 12 1989 | 3. TIME OF DEATH: M |
| 4. SOCIAL SECURITY NUMBER: 232-46-3790 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs, last birthday): 64 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): 7-21-25 | 8. BIRTHPLACE (State or Foreign Country): VA. |
| 9a. FACILITY NAME (If not institution, give street and number): 404 HAZLETT AVE. | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: BALTIMORE | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 404 HAZLETT AVE. | | 10f. ZIP CODE: 21229 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): KITCHEN PRO | 16b. KIND OF BUSINESS/INDUSTRY: WENDY'S |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): GEORGE W. THOMPSON | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA PEARL PARLETTE |
| 19a. INFORMANT'S NAME (Type/Print): SUSAN SHIFFLETT | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404 HAZLETT AVE. BALT. MD 21229 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BALT. WASH. CREMATORY | 20c. LOCATION — City or Town, State: CAMEL, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Allen Slack MC005335 | 22. NAME AND ADDRESS OF FACILITY: SLACK FUNERAL HOME PO BOX 248 ELLICOTT CITY, MD. 21043 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. cardio pulmonary Arrest | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Lung CANCER | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Chronic Lung dz

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Troy Scoggins MD | 29c. LICENSE NUMBER: D36185 | 29d. DATE SIGNED (Month, Day, Year): 10/13/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Dept. of Radiation Oncology - Univ. of Maryland Hosp. Balt. MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 17 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-18 Rev 1/89

89 2992

89 29963

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gregory Lawrence Doyle
2. DATE OF DEATH (Month Day Year): 10-18-89
3. TIME OF DEATH: 8:16 PM
4. SOCIAL SECURITY NUMBER: N/A
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs., last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS 10 / MIN 13
7. DATE OF BIRTH (Month Day Year): 10-18-89
8. BIRTHPLACE (State or Foreign Country): Baltimore, MD
9a. FACILITY NAME (If not institution, give street and number): University Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Severn
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 1724 Village Square Court
10f. ZIP CODE: 21144
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A
16b. KIND OF BUSINESS/INDUSTRY: N/A

17. FATHER'S NAME (First, Middle, Last): Gary Louis Doyle, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Glenda Johnson

19a. INFORMANT'S NAME (Type/Print): Glenda Johnson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1724 Village Sq.Ct. Severn, MD 21144

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory
20c. LOCATION — City or Town, State: Baltimore, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 851 Annapolis Road, Gambrills, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | SEVERE LUNG IMMATURITY | 10HR |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Extreme Prematurity | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year):
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Iyad Aljabi, MD.
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IYAD ALJABI, MD. U. of MD Hosp. - Dept. of Peds., Div. of Neonatology

31. DATE FILED (Month, Day, Year): 10/18/89 OCT 23 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29964

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate must be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| KELLY | LYNNE | DUNNING | 10 10 1989 | 8:05A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 222-64-5043 | 1 ☐ M 2 ☒ F | 23 YRS. | | | 08-20-66 | Del. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| University Hospital | Baltimore | City |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Del. | Sussex | Seaford | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Lot 22 Pine Ridge Trailer Park | 19973 | U. S. A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 8+) | | |
| 12 | | Sales Clerk | Royal Farms Store |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| John T. Whaley | Faith Ann Johnson |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| John Henry Dunning, Jr. | Lot 22 Pine Ridge Trailer Park, Seaford Del 19973 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Blades Cemetery | Blades Delaware |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| John A. Barranco | 495 Ritchie Hwy. Barranco Funeral Home Severna Park, MD 21146 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Head and neck injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☒ YES 2 ☐ NO | HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 10-6-89 | 11:42P M | 1 ☐ YES 2 ☒ NO | Passenger of auto/auto impact. |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| road | Delaware-Brooklyn Aves., Laurel Delaware |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Frank J. Peretti, M.D. | OCME | ▶ 10-11-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Frank J. Peretti, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 17 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 • FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Pages ___ to be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ___ should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOSEPH ANTONIO GRAY
2. DATE OF DEATH (Month, Day, Year): OCTOBER 5, 1989
3. TIME OF DEATH: 10:37 A M
4. SOCIAL SECURITY NUMBER: None
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 1 DAYS 1 — IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept 4 1989
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Beltsville
10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4426 Powder Mill Rd
10f. ZIP CODE: 20705
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ___ College (1-4 or 5+): ___
16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Clarence Gray
18. MOTHER'S NAME (First, Middle, Maiden Surname): Gail Amoroso
19a. INFORMANT'S NAME (Type/Print): Gail A. Gray (Mother)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4426 Powder Mill Rd, Beltsville, Md 20705
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) ___
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory
20c. LOCATION — City or Town, State: Washington, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden
22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home 20850, 246 N.Washington St, Rockville, Md

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | Necrotizing Enterocolitis | 20 hours |
| DUE TO (OR AS A CONSEQUENCE OF): b. | prematurity | 30 days |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c. | | |
| DUE TO (OR AS A CONSEQUENCE OF): d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Mary M. Torchia, M.D.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 10/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARY M TORCHIA, M.D. % JOHNS HOPKINS HOSPITAL - 600 N. Wolfe St. Balto. MD 21205
31. DATE FILED (Month, Day, Year): 10/5/89 OCT 11 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

89 29966

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH Month / Day / Year | 3. TIME OF DEATH |
|---|---|---|---|---|
| JAMES | FRANK | GUEST, III | 10 / 14 / 1989 | 10:08 A M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 220-70-0207 | 1 [X] M 2 [ ] F | 32 YRS. | | | 9/12/57 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| Harbor Hospital Center | Baltimore | Baltimore City |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Harford | Aberdeen | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 704 Custis Street | 21001 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Peacetime | 1 [ ] YES 2 [X] NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | 2 | HLJ Management | U.S. Govt. |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| James F. Guest, II | Leona Tongue |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Mrs. Sylvia L. Guest | 704 Custis St., Aberdeen, Maryland 21001 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | R. A. Ferris & Co. | West Chester, Pa. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Kenneth B. Cargo | Tarring Funeral Home, P.A. Aberdeen, Maryland 21001-3399 |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Anoxic encephalopathy | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Cocaine intoxication | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [X] YES 2 [ ] NO | 1 [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [X] YES 2 [ ] NO | HOSPITAL: [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [X] Could not be determined | 10-6-89 | M | 1 [ ] YES 2 [X] NO | Unknown |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Unknown | Unknown |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita Korell | OCME | ▶ 10-15-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Margarita A. Korell, M.D. 111 Penn St., Balto., MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 16 '89 | Julia Davidson-Randall |

DHMH-1S Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 22966

89 29967

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Mary Elizabeth Holman | | | 2. DATE OF DEATH (Month, Day, Year): 10-19-89 | 3. TIME OF DEATH: 5:40 PM |
| 4. SOCIAL SECURITY NUMBER: 214-64-3568 | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7-28-11 | 8. BIRTHPLACE (State or Foreign Country): Virginia |
| 9a. FACILITY NAME (If not institution, give street and number): Childrens Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | 9c. COUNTY OF DEATH: City Md. 21211 | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Owings Mills | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6 Walk Ave. | 10f. ZIP CODE: 21117 | 10g. CITIZEN OF WHAT COUNTRY?: USA. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | |
|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking |
| 17. FATHER'S NAME (First, Middle, Last): John Henry Crabtree | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Sara Nancy Elizabeth Shannon | |
| 19a. INFORMANT'S NAME (Type/Print): William H. Holman | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4606 Mt. Carmel Rd., Hampstead, Md. 21074 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Springfield Cemetery | 20c. LOCATION — City or Town, State: Sykesville, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. G. Eckhardt | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel Owings Mills, Md. 21117 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Aspiration | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Multiple Cerebrovascular accidents | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. pneumonia, | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

| | | | |
|---|---|---|---|
| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: S C Kline | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Samuel C Kline Childrens Hospital Balt MD | | |
| 31. DATE FILED (Month, Day, Year): OCT 20 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

89 29968

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): CHARLENE HOLCOMB

**2. DATE OF DEATH** (Month, Day, Year): 10 / 14 / 89

**3. TIME OF DEATH**: 12:50P M

**4. SOCIAL SECURITY NUMBER**: 215-72-4898

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 21 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): 12-20-67

**8. BIRTHPLACE** (State or Foreign Country): Havre de Grace

**9a. FACILITY NAME** (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

**9b. CITY, TOWN OR LOCATION OF DEATH**: BALTIMORE CITY

**9c. COUNTY OF DEATH**: BALTIMORE

**RESIDENCE OF DECEDENT**

**10a. STATE**: Maryland

**10b. COUNTY**: Harford

**10c. CITY, TOWN OR LOCATION**: Havre de Grace

**10d. INSIDE CITY LIMITS?** 1 ☒ YES 2 ☐ NO

**10e. STREET AND NUMBER**: 350 Girard Street

**10f. ZIP CODE**: 21078

**10g. CITIZEN OF WHAT COUNTRY?**: U.S.

**11. MARITAL STATUS**: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X

**14. RACE — American Indian, Black, White, etc.** Specify: White

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): High School '85
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): Student

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): Richard Cofer Holcomb

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): Sally Brown Holcomb

**19a. INFORMANT'S NAME** (Type/Print): Mr. Richard C. Holcomb

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 350 Girard Street, Havre de Grace, MD 21078

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): Conowingo Baptist Church Cem.

**20c. LOCATION — City or Town, State**: Cecil County, MD

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Madelyn Mitchell Shank

**22. NAME AND ADDRESS OF FACILITY**: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St., HdG, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such ee cerdiec or reepiratory erreat, shock, or haert failure. List only one cause on esch line.**

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) → | a. Probable Pulmonary hemorrhage | 12 hours |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentielly list conditions, if any, leading to immedlets cause. Enter UNDERLYING CAUSE (Disese or injury that initiated events resulting in desth) LAST | b. Pseudomonas Pneumonia | 10 days |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Cystic Fibrosis | 21 years |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

**PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.**

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☒ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☒ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc.** (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner ee stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: M. Pierce MD

**29c. LICENSE NUMBER**:

**29d. DATE SIGNED** (Month, Day, Year): ▶ 10/14/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print): MARY C. PIERCE 600 N. WOLFE ST. JOHNS HOPKINS HOSP. BALTIMORE MD

**31. DATE FILED** (Month, Day, Year): OCT 19 '89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 2926

89 29969

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): DOROTHY Estelle HUNTLEY | | | 2. DATE OF DEATH: MONTH 10 DAY 18 YEAR 89 | 3. TIME OF DEATH: 2:18 P M |
| 4. SOCIAL SECURITY NUMBER: 148-12-2803 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 08-31-25 | 8. BIRTHPLACE (State or Foreign Country): New Jersey |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: Anne Arundel | 10c. CITY, TOWN OR LOCATION: Annapolis | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 1038 Mountain Top Drive | | 10f. ZIP CODE: 21401 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary | 16b. KIND OF BUSINESS/INDUSTRY: AA Co. School Bd. | |
| 17. FATHER'S NAME (First, Middle, Last): Russell L. Snyder | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Imhoff | |
| 19a. INFORMANT'S NAME (Type/Print): Howard C. Huntly | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1038 Mountain Top Drive, Ann, MD 21401 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restland Memorial Park | 20c. LOCATION — City or Town, State: West Hanover, NJ |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | | 22. NAME AND ADDRESS OF FACILITY: Hardesty Funeral Home P.A. 12 Ridgley Ave. Annapolis, MD 21401 | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Arteriosclerotic cardiovascular disease | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO — Inspection | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: OCME | 29d. DATE SIGNED (Month, Day, Year): 10-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D., Assistant 111 Penn Street Baltimore, Md. 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 20 1989 | 32. REGISTRAR'S SIGNATURE: Gisha Davidson-Kendall |

ONMN-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29970

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| EARL | MARCELLIUS | JEROMES | 10 4 89 | 9:36 P M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 577-82-6521 | 1 [X] M 2 [ ] F | 18 YRS. | | | Aug. 22, 1989 | D. C. |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| 815 Thayer Ave. | BALTIMORE CITY | |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| D. C. | | Washington | 1 [X] YES 2 [ ] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1508 Webster Street, N. W. | 20011 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 11 | | Student | Public Schools |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Earl H. Jerome | Anita C. Williams |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Anita C. Williams | 1508 Webster Street, N.W. Washington, D.C. 20011 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Washington National Cemetery | Suitland, Md. |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| Lawrence G. Haller 816 | R. N. Horton Co. Morticians, Inc. 600 Kennedy STreet, N. W. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. 2 GUNSHOT WOUNDS TO UPPER BACK | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [XX] YES 2 [ ] NO | 1 [XX] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) |
|---|---|
| [XX] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [XX] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide [XXX] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 10-4-89 | M | 1 [ ] YES 2 [XX] NO | SUBJECT WAS SHOT |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| HOME | 815 THAYER AVE., SILVER SPRING MONTGOMERY, MD |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [XX] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 10-5-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print)

Julia C. Goodin,M.D. 111 Penn St. Baltimore,MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 12 '89 | Julia Davidson-Randall |

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

25

89 29971

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): THEODORE JESKE | | | | | | 2. DATE OF DEATH (Month, Day, Year): 10 18 89 | 3. TIME OF DEATH: 6:20 P M |
| 4. SOCIAL SECURITY NUMBER: 399-07-6675 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | 7. DATE OF BIRTH (Month, Day, Year): 1-29-24 | 8. BIRTHPLACE (State or Foreign Country): WISCONSIN |
| 9a. FACILITY NAME (If not institution, give street and number): Central District Detention Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | | | 9c. COUNTY OF DEATH: | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: MD | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: ELLICOTT CITY | | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: 9121 WHITEHALL RD | | 10f. ZIP CODE: 21043 | | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W.W. II | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOYED | | | | 16b. KIND OF BUSINESS/INDUSTRY: HOME IMPROVEMENTS | |
| 17. FATHER'S NAME (First, Middle, Last): THEODORE P. JESKE | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CLOTILDE KRENZ | | | | | |
| 19a. INFORMANT'S NAME (Type/Print): CLAIRE JESKE | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9121 WHITEHALL RD ELLICOTT CITY MD 21043 | | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WOODLAWN | | | | 20c. LOCATION — City or Town, State: WOODLAWN MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke | | 22. NAME AND ADDRESS OF FACILITY: 4112 COLUMBIA PK. ELLICOTT CITY MD 21043 | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XXX 1 [ ] YES 2 [ ] NO | XXX 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 XXYES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 XXOther (Specify) SCENE |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| XX 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XXX [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Margarita Anne Korell | OCME | ▶ 10-19-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Margarita A. Korell, M.D. - Assistant 111 Penn Street, Baltimore, MD 21201

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 20 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

6

Trees 89

KINGSLEY, LORRAINE A
07/26/21 F

89 29972

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LORRAINE ANN KINGSLEY | | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 21, 1989 | 3. TIME OF DEATH: 10:12P M |
| 4. SOCIAL SECURITY NUMBER: 502-10-4826 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 7-26-1921 | 8. BIRTHPLACE (State or Foreign Country): North Dakota |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Montgomery | 10c. CITY, TOWN OR LOCATION: Colesville | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 13109 Buccaneer Road | | 10f. ZIP CODE: 20904 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1-12; College (1-4 or 5+): N/A | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: own home | |
| 17. FATHER'S NAME (First, Middle, Last): Thomas Meagher | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Horgan | |
| 19a. INFORMANT'S NAME (Type/Print): Thomas Henry Kingsley | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13109 Buccaneer Road, Colesville, Md. 20904 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Lawrence Cemetery | 20c. LOCATION — City or Town, State: Faribault, Minnesota | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] | 22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Adenocarcinoma of lung | 2 mo |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | | |
|---|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD | | 29c. LICENSE NUMBER: P03051 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10/21/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G.M. Jenkins, MD John Hopkins Hospital, Baltimore, Md. | | | |
| 31. DATE FILED (Month, Day, Year): OCT 23 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | | |

DHMH-16 Rev 1/89

10

NCCU7

1 112 86 74 A
KIPP, RICHARD W 89 29973
01/11/29 M

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): RICHARD W KIPP | | | | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 16, 1989 | | 3. TIME OF DEATH: 11:05 A M |
| 4. SOCIAL SECURITY NUMBER: 212-26-5126 | 5. SEX: XX 1 M 2 F | 6. AGE (In yrs. last birthday): 60 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Jan.11,1929 | | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | | | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | | 9c. COUNTY OF DEATH: BALTIMORE | | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Md. | 10b. COUNTY: Anne Arundel | | 10c. CITY, TOWN OR LOCATION: Annapolis | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | |
| 10e. STREET AND NUMBER: 1828 George Ave. | | | 10f. ZIP CODE: 21401 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 11. MARITAL STATUS: 1 Never Married 2 Married 3 Widowed XX 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES: 1952-1954 | | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Photo Engraver | | 16b. KIND OF BUSINESS/INDUSTRY: Engraving | | |
| 17. FATHER'S NAME (First, Middle, Last): Hiram C. Kipp | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn M. Pryor | | | | |
| 19a. INFORMANT'S NAME (Type/Print): Evelyn K. Jarrett | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11315 Garrison Forest Rd., Owings Mills, Md. 21117 | | | | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Garrison Forest Veterans Cem. | | 20c. LOCATION — City or Town, State: Owings Mills, Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. Eckhardt | | | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. 21117 | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Gastrointestinal Bleeding | 24 hrs |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Liver failure | 1 1/2 wks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | c. Sepsis | 1 wk |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| | d. Alcoholic Cirrhosis of Liver | yrs |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intracerebral hemorrhage

24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA; OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 YES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert E. Stuby MD PhD Resident - Anesthesiology + Critical Care

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): ▶ 10/16/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert E. Stuby MD PhD Johns Hopkins Hospital 600 N Wolfe St Baltimore MD 21205

31. DATE FILED (Month, Day, Year): OCT 17 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29974

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARY C. G. KLEIN | | | | 2. DATE OF DEATH (Month, Day, Year): 10 20 89 | 3. TIME OF DEATH: 625 PM |
| 4. SOCIAL SECURITY NUMBER: 212-07-4912 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 90 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): 6-19-99 | 8. BIRTHPLACE (State or Foreign Country): MARYLAND |
| 9a. FACILITY NAME (If not institution, give street and number): Howard Hospital Ctr. | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: - |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: HOWARD | 10c. CITY, TOWN OR LOCATION: ELKRIDGE | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6326 BEECHFIELD AVENUE | 10f. ZIP CODE: 21227 | 10g. CITIZEN OF W[illegible] COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 8+): - | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS | 16b. KIND OF BUSINESS/INDUSTRY: CLOTHING MFG. | |
| 17. FATHER'S NAME (First, Middle, Last): WILLIAM E. GILLISS | 18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY F. MOLESWORTH | | |
| 19a. INFORMANT'S NAME (Type/Print): FRANCES H. BREEDEN | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7 HOPKINS ST. GLEN BURNIE, MARYLAND 21061 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOWRIDGE MEMORIAL PARK | 20c. LOCATION — City or Town, State: ELKRIDGE, MD. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary L. Kaufmann | 22. NAME AND ADDRESS OF FACILITY: Fink Funeral Home GLEN BURNIE, MD. 21061 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Probable Sepsis | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NFDDM
OBS
Skin CA (nose)

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] - house physician | 29c. LICENSE NUMBER: | 29d. DATE SIGNED (Month, Day, Year): 10-20-89. |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] TREMAROLI 300 S. Hanover St Baltimore, Md | | |
| 31. DATE FILED (Month, Day, Year): OCT 23 1989 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-18 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 29975

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LAWRENCE LOUDERMILK
2. DATE OF DEATH (Month, Day, Year): 10 / 14 / 1989
3. TIME OF DEATH: 2:26 p M
4. SOCIAL SECURITY NUMBER: 217-34-6115
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 8/21/34
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore City
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1920 Casadel Avenue
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Lester E. Loudermilk
18. MOTHER'S NAME (First, Middle, Maiden Surname): Georgia G. Lewis
19a. INFORMANT'S NAME (Type/Print): Mildred L. Friend
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1920 Casadel Avenue, Balto., Md. 21230
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Kaufman
22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes, 5695 Main Street, Elkridge, Md. 21227

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. | LIVER ~~FAILURE~~ DISEASE / Cirrhosis | 20 Years |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. | Hepatorenal syndrome | Two Weeks |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| c. | Bleeding Coagulopathy. | One week |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| d. | | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Strangulated Ventral Hernia
Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: JAYA Jayawardena Surgical Resident
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 10-14-89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAYAWARDENA, HARSHA, MD, ST AGNES HOSPITAL 900, Caton Avenue Baltimore
31. DATE FILED (Month, Day, Year): 10-14-89.
32. REGISTRAR'S SIGNATURE: OCT 18 '89 Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29976

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MARIE MAZUR | | | | 2. DATE OF DEATH (Month, Day, Year): 10 17 89 | 3. TIME OF DEATH: 6 00 PM |
| 4. SOCIAL SECURITY NUMBER: 181-16-3364 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | | 7. DATE OF BIRTH (Month, Day, Year): 11 16 1921 | 8. BIRTHPLACE (State or Foreign Country): Austria |
| 9a. FACILITY NAME (If not institution, give street and number): Mercy Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | | 9c. COUNTY OF DEATH: City | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Randallstown | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4 Albess Court Apt. 103 | | 10f. ZIP CODE: 21133 | 10g. CITIZEN OF WHAT COUNTRY?: USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Domestic | |
| 17. FATHER'S NAME (First, Middle, Last): Samuel Frisch | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Francesca Jakuvovich | |
| 19a. INFORMANT'S NAME (Type/Print): Abraham Mazur | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 Albess Court, Apt. 103, Randallstown, MD 21133 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oheb Shalom Cemetery | 20c. LOCATION — City or Town, State: Reisterstown, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Marzullo | | 22. NAME AND ADDRESS OF FACILITY: Hebrew Memorial Funeral Home, Inc. 1100 Reisterstown Rd., Pikesville, MD | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Metastatic Breast Carcinoma Brain, Lung, Liver DUE TO (OR AS A CONSEQUENCE OF): | 3yrs |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Systemic hypererythrosis
Chronic anemia

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Marvin J. Feldman MD | 29c. LICENSE NUMBER: D 7930 | 29d. DATE SIGNED (Month, Day, Year) ▶ 10-17-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mercy Med Center, 301 St. Paul Place, Balt., Md 21202 | | |
| 31. DATE FILED (Month, Day, Year): OCT 23 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely ... by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| William | Robert | McLaughlin | 10-23-89 | 5:35PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 213-02-3551 | 1 [X] M 2 [ ] F | 18 YRS. | | | 02 25 71 | Maryland |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| University Hospital | Baltimore City | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Talbot | Cordova | 1 [ ] YES 2 [X] NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| Route 1, Box 249 | 21625 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced | 1 [ ] YES 2 [X] NO | 1 [ ] YES 2 [X] NO Specify: | Specify: white |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 11 | | Student | |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Elmer Wardell McLaughlin | Sandra Ernst |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Wm Elmer McLaughlin | P O Box 167 Cordova MD 21625 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 10/26/89 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | Spring Hill Cemetery | Easton, Maryland |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ JOHN R. MERLER | Newnam Funeral Home<br>Easton, Maryland |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Cranio-cerebral injuries | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| [X] YES 2 [ ] NO | [X] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| [X] YES 2 [ ] NO | HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [ ] Natural 5 [ ] Pending investigation<br>2 [X] Accident<br>3 [ ] Suicide 6 [ ] Could not be determined<br>4 [ ] Homicide | 10-21-89 | 6:15AM M | 1 [ ] YES 2 [X] NO | Driver in auto/fixed object impact |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| | road | | | 3300 Beechwood Drive, Baltimore City, Maryland |

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| | OCME | ▶ 10-24-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
James Kaplan, M.D. 111 Penn Street, Baltimore, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 25 '89 | Julia Davidson-Randall |

DHMH-18 Rev 1/89

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DOE, JOHN
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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEOENT'S NAME (First, Middle, Last): FRANK JOHN MEYER | | | 2. DATE OF DEATH: MONTH 10 DAY 14 YEAR 89 | 3. TIME OF DEATH: 827 AM |
| 4. SOCIAL SECURITY NUMBER: 094-03-5491 | 5. SEX: 1 X M 2 ☐ F | 6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): SEPT. 22, 1912 | 8. BIRTHPLACE (State or Foreign Country): NEW YORK |
| 9a. FACILITY NAME (If not institution, give street and number): University of Maryland Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore | 9c. COUNTY OF DEATH: N/A | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MARYLAND | 10b. COUNTY: CARROLL | 10c. CITY, TOWN OR LOCATION: TANEYTOWN, MARYLAND | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO |
| 10e. STREET AND NUMBER: BOX 21 SHOEMAKER ROAD | | 10f. ZIP CODE: 21787 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PLUMBER | 16b. KIND OF BUSINESS/INDUSTRY: PLUMBING CONTRACTOR |
| 17. FATHER'S NAME (First, Middle, Last): FRANK MEYER | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA M. TANGER | |
| 19a. INFORMANT'S NAME (Type/Print): RICHARD A. MEYER | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 HILLBERRY CIRCLE HOLBROOK, NEW YORK 11741 | |
| 20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MELVILLE CEMETERY | 20c. LOCATION — City or Town, State: MELVILLE, NEW YORK |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ P. Kevin Judy | | 22. NAME AND ADDRESS OF FACILITY: SKILES FUNERAL HOME, 136 EAST BALTIMORE ST. TANEYTOWN, MARYLAND 21787 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Rupture Aortic Aneurysm Abdominal | 24 hour |
| DUE TO (OR AS A CONSEQUENCE OF): | b. Arteriosclerosis | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): | c. | |
| DUE TO (OR AS A CONSEQUENCE OF): | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Old Age
Coronary Artery Disease

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Eric D Strauch M.D | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10-14-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eric Strauch 22 S. Greene Street Balto. MD 21201

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 18 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall |

DHMH-16 Rev 1/89

6

89 29979

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) BERNICE MYERS | | | | | 2. DATE OF DEATH MONTH DAY YEAR 10-11-89 | | 3. TIME OF DEATH 2:50PM M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday) 71 YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) Feb. 04, 1918 | | 8. BIRTHPLACE (State or Foreign Country) Maryland |
| 9a. FACILITY NAME (If not institution, give street and number) 603 N. CALHOUN STREET | | | 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY | | | 9c. COUNTY OF DEATH | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE Maryland | 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Baltimore | | | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO | |
| 10e. STREET AND NUMBER 603 N. Calhoun Street | | | 10f. ZIP CODE 21217 | | 10g. CITIZEN OF WHAT COUNTRY? USA | | |
| 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: Black | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 0-7 College (1-4 or 5+): | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic | | | 16b. KIND OF BUSINESS/INDUSTRY | |
| 17. FATHER'S NAME (First, Middle, Last) James Myers | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Foote | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Gladys Ball | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 239 St. Inigoes, Md 20684 | | | | |
| 20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Johns Church Cemetery | | | 20c. LOCATION — City or Town, State Lusby, Md | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Spencer E. Sewell | | | 22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, Md | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 XX NO INSPECTION | 1 ☐ YES XX ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX 1 YES 2 ☐ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home XX 5 Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 XX Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Julia C. Goodin | OCME | ▶ 10-12-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JULIA C. GOODIN, MD 111 PENN STREET, BALTIMORE, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 20 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

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ER# 1505072
U 26 42 11 89 29980

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Henry M. Patterson | | | 2. DATE OF DEATH (Month / Day / Year): 10 / 7 / 89 | 3. TIME OF DEATH: 0103 AM |
| 4. SOCIAL SECURITY NUMBER: 212-01-5554 | 5. SEX: 1 ☐ M 2 ☐ F (X) | 6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 7/23/00 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hpspital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Balto. City | | 9c. COUNTY OF DEATH: Baltimore |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Balto. | 10c. CITY, TOWN OR LOCATION: Catonsville | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 (X) NO |
| 10e. STREET AND NUMBER: 711 Maiden Choice Lane 21228 | | 10f. ZIP CODE: 21228 | 10g. CITIZEN OF WNAT COUNTRY?: U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 (X) Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 (X) NO. IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 (X) NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Ten Years; College (1-4 or 5+): ------ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-Employed (Retired) | 16b. KIND OF BUSINESS/INDUSTRY: Eastern Sales & Engineering Company | |
| 17. FATHER'S NAME (First, Middle, Last): James D. Patterson | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara G. Hasson | |
| 19a. INFORMANT'S NAME (Type/Print): Carolene C. Patterson | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 711 Maiden Choice Lane, Catonsville, Md. 21228 | |
| 20a. METHOD OF DISPOSITION: 1 (X) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hopewell Cemetery | 20c. LOCATION — City or Town, State: Port Deposit, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert J. Patterson Sr. | | 22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home Perryville, Maryland | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Asystole
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 (X) NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 (X) NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 (X) ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 (X) Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 (X) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Debra Fellmuth M.D. | 29c. LICENSE NUMBER: D37031 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-7-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 711 Maiden Choice Lane, Catonsville, MD 21228 | | |
| 31. DATE FILED (Month, Day, Year): OCT 10 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DNMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

6

Item:11 per FH G-658
12-6-89 cm

89 29981

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JERRY V. PIPPIN, Sr. | | | 2. DATE OF DEATH MONTH: October DAY: 10 YEAR: 1989 | 3. TIME OF DEATH: 11:52 A.M. |
| 4. SOCIAL SECURITY NUMBER: 918-36-9998 | 5. SEX: 1 ☑ M 2 ☐ F | 6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): July 18 1939 | 8. BIRTHPLACE (State or Foreign Country): Tennessee |
| 9a. FACILITY NAME (If not institution, give street and number): Bon Secour Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City | | 9c. COUNTY OF DEATH: |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| Maryland | Baltimore City | Brooklyn | 1 ☒ YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1150 Monroe Circle | 21225 | U.S.A. |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☒ Divorced | 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Truck Driver | Fleet Transport |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Jack Wilson | Irene Pippin |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Irene Showalter | 1150 Monroe Cir., Baltimore, MD 21225 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Glen Haven Memorial Park | Glen Burnie, A.A., MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Kirkley Funeral Home 421 Crain Hwy. S.E., Glen Burnie, MD 21061 |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARDIAC ARREST - MYOCARDIAL INFARCTION | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. GENERALIZED VASCULAR DISEASE | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. ~~DIABETIC VASCULOPATHY~~ | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. ISCHEMIC LIVER DISEASE. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE KIDNEY DISEASE

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Curtis E Davis MD | D-21240 | ▶ 10 OCT |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BON SECOURS HOSP 21223 CURTIS E DAVIS M.D

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 12 1989 | Julia Davidson-Rhodes |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in ... by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29982

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 is the burial-transit permit. Pages 1, 2, 3 should
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|---|
| PAUL | A. | RUSSELL | 10-3-89 | 6:03PM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 579-86-4264 | 1 X M 2 ☐ F | 30 YRS. | | | Aug. 5, 1959 | Jamaica |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| WABASH & W. Coldspring | BALTIMORE CITY | |

**RESIDENCE OF DECEDENT**

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| D.C. | | Washington, D.C. | 1 X YES 2 ☐ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1305 Rittenhouse Street, N.W. | 20011 | United States |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☐ X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 X NO | 1 ☐ YES 2 X NO Specify: | Specify: Black |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 12 | | Music Producer | Music |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Keith Russell | Winnifred Grey |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Winnifred Grey | 1305 Rittenhouse Street, N.W. Washington, D.C. 20011 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Gate of Heaven Cemetery | Silver Spring, MD |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ Wilbur R. Briggs | McGuire Funeral Service 7400 Georgia Ave. N.W. Washington, D.C. |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. MULTIPLE GUNSHOT WOUNDS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XXX YES 2 ☐ NO | XXX YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) HOSPITAL: | OTHER: |
|---|---|---|
| XX YES 2 ☐ NO | 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | 4 ☐ Nursing Home 5 ☐ Residence XXX Other (Specify) SCENE |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURRED |
|---|---|---|---|---|
| 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 XX Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 8-3-89 | 5:49 PM | 1 ☐ YES XX NO | Subject shot |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| Street | WABASH & COLD SPRING W., BALTO., MARYLAND |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Mario F. Golle Jr MD | OCME | ▶ 10-4-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARIO F. GOLLE, JR.MD 111 PENN STREET, BALTIMORE, MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 11 '89 | Julia Davidson-Randall |

5

DHMH-16 Rev 1/89

89 29983

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): LINDA CAROL SIAS | | 2. DATE OF DEATH (Month, Day, Year): OCTOBER 19, 1989 | 3. TIME OF DEATH: 12:10P M |
| 4. SOCIAL SECURITY NUMBER: 216-82-4504 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 29 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 12/23/59 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL | 9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY | 9c. COUNTY OF DEATH: BALTIMORE | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: | 10c. CITY, TOWN OR LOCATION: Baltimore City | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 314 S. Norris Street | 10f. ZIP CODE: 21223 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: white |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unemployed | 16b. KIND OF BUSINESS/INDUSTRY: | |
| 17. FATHER'S NAME (First, Middle, Last): Freddie L. Sias | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth Beard | | |
| 19a. INFORMANT'S NAME (Type/Print): Elizabeth A. Reely | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 312 S. Norris Street, Balto., Md. 21223 | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Loudon Park Crematory | 20c. LOCATION — City or Town, State: Balto., Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary L. Kaufman | 22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes 5695 Main St., Elkridge, Md. 21227 | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Fulminant hepatitis B | 2 months |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. intravenous drug abuse | 1 YR. |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Pneumonia or Adult respiratory distress syndrome

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | |

| | | | |
|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO |
| 28d. DESCRIBE HOW INJURY OCCURED | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: L Simonson MD | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/19/89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lisa A Simonson MD | | |
| 31. DATE FILED (Month, Day, Year): OCT 24 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

DHMH-16 Rev 1/89

89 29984

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JEAN SPIRLET — JEAN SPIRLET
2. DATE OF DEATH — MONTH: 10 DAY: 15 YEAR: 89
3. TIME OF DEATH: 6 30 A M
4. SOCIAL SECURITY NUMBER: 579 40 0755
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 57 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11 25 931
8. BIRTHPLACE (State or Foreign Country): FLORIDA
9a. FACILITY NAME (If not institution, give street and number): University of Maryland
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimor
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George'S
10c. CITY, TOWN OR LOCATION: Bowie Maryland
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3616 Mabank Lane
10f. ZIP CODE: 20715
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ ND — IF YES, GIVE WAR OR DATES: No
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: No
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): ---------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Alva Johnston
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Farmer
19a. INFORMANT'S NAME (Type/Print): Gilbert Spirlet
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3616 Mabank Lane Bowie Maryland 20715
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY
20c. LOCATION — City or Town, State: Alexandria Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pres.
22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Progressive squamous Ca of base of tongue
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Flavio Kruter
29c. LICENSE NUMBER: D 35 398
29d. DATE SIGNED (Month, Day, Year): ▶ 10/15/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FLAVIO KRUTER 22 SOUTH GREEN BALTIMORE, MD 21209
31. DATE FILED (Month, Day, Year): OCT 20 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

DHMH-16 Rev 1/89

(10)

#8665 03

89 29985

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH (Month, Day, Year) | 3. TIME OF DEATH |
|---|---|---|---|
| ERIC | WILLIAMS | 10-12-89 | 11:10AM M |

| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
|---|---|---|---|---|---|---|
| 382-90-1175 | 1 ☒ M 2 ☐ F | 16 YRS. | | | 05-28-73 | Wisconsin |

| 9a. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TOWN OR LOCATION OF DEATH | 9c. COUNTY OF DEATH |
|---|---|---|
| UNIVERSITY HOSPITAL | BALTIMORE CITY | ~~XXXXXXXXXX~~ Balt. |

RESIDENCE OF DECEDENT

| 10a. STATE | 10b. COUNTY | 10c. CITY, TOWN OR LOCATION | 10d. INSIDE CITY LIMITS? |
|---|---|---|---|
| MD | Anne Arundel | Crofton | 1 ☐ YES 2 ☒ NO |

| 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? |
|---|---|---|
| 1602 W. Bancroft Lane | 21114 | USA |

| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) | 14. RACE — American Indian, Black, White, etc. |
|---|---|---|---|
| 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO Specify: | Specify: White |

| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | 16b. KIND OF BUSINESS/INDUSTRY |
|---|---|---|---|
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | |
| 10 | | Student | Schooling |

| 17. FATHER'S NAME (First, Middle, Last) | 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
|---|---|
| Darrell W. Williams | Theresa K Effert |

| 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
|---|---|
| Theresa Effert | 1602 W. Bancroft Lane, Crofton, MD 21114 |

| 20a. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LOCATION — City or Town, State |
|---|---|---|
| 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Wood National Cemetery | Milwaukee, WI |

| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND ADDRESS OF FACILITY |
|---|---|
| ▶ [signature] | Hardesty Funeral Home 21054<br>851 Annapolis Road, Gambrills MD |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. HEAD INJURY WITH COMPLICATIONS | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| XX 1 ☒ YES 2 ☐ NO | XX YES 2 ☐ NO |
| PARTIAL | |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| XX 1 ☒ YES 2 ☐ NO | HOSPITAL: XX 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☐ Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 10-5-89 | 7:47PM | 1 ☐ YES 2 XX NO | DRIVER IN AUTO/FIXED OBJECT |

| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
|---|---|
| ROAD | MISORS STA. RD/GRAYSFORD RD. ANNE ARUNDEL COUNTY, MD |

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| [signature] | OCME | ▶ 10-13-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MARIO F. GOLLE, JR.,MD 111 PENN STREET,BALTIMORE,MD 21201 VC

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 13 1989 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the local registrar prior to burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

15

ITEM:18 per FH
G-676 6/17/91 cm

89 29986

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) Mauricio Isadora Zeplo / Mauricio Zeplo | | | 2. DATE OF DEATH (Month, Day, Year) October 16, 1989 | 3. TIME OF DEATH 02:00 pM |
| 4. SOCIAL SECURITY NUMBER 509-46-3391 | 5. SEX 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday) 61 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year) Feb.22,1928 | 8. BIRTHPLACE (State or Foreign Country) Argentina |
| 9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City | | 9c. COUNTY OF DEATH — |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE Maryland | 10b. COUNTY Harford | 10c. CITY, TOWN OR LOCATION Joppatowne | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER 742 Joppa Farm Road | | 10f. ZIP CODE 21085 | 10g. CITIZEN OF WHAT COUNTRY? USA |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physician | 16b. KIND OF BUSINESS/INDUSTRY Medical |
| 17. FATHER'S NAME (First, Middle, Last) Edwrague — Czeplowodozki | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) ELISA SCHENKER Elisa — Shinkar | |
| 19a. INFORMANT'S NAME (Type/Print) Barbara A. Solomon | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2302 Weathervane Road, Baltimore, Md. 21234 | |
| 20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery | 20c. LOCATION — City or Town, State Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard K McComas III | | 22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Prolonged Cardiac Arrest — DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Anoxic Brain Damage — DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. Coronary Artery Disease — DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Congestive Heart Failure

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER M. Mohedin | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) ▶ 10/16/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mohamed Mohedin, M.D. c/o Maryland General Hospital

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year) OCT 18 '89 | 32. REGISTRAR'S SIGNATURE Julia Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

B

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89 29987

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Paul Edward Anthony | | | | | 2. DATE OF DEATH (Month, Day, Year): Sept. 20, 1989 | | 3. TIME OF DEATH: AM |
| 4. SOCIAL SECURITY NUMBER: 220-03-1476 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 71 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 7. DATE OF BIRTH (Month, Day, Year): Oct. 13, 1917 | | 8. BIRTHPLACE (State or Foreign Country): Greensboro, Md. |
| 9a. FACILITY NAME (If not institution, give street and number): Rt. 1, Box CL 1, (Bethlehem) | | | 9b. CITY, TOWN OR LOCATION OF DEATH: Preston, Maryland | | | 9c. COUNTY OF DEATH: Caroline | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Caroline | 10c. CITY, TOWN OR LOCATION: Preston, | | | | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO | |
| 10e. STREET AND NUMBER: Rt. 1, Box CL 1 | | | 10f. ZIP CODE: 21655 | | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII | | 13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | | | 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 / College (1-4 or 6+) | | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter-Contractor | | | 16b. KIND OF BUSINESS/INDUSTRY: Building | |
| 17. FATHER'S NAME (First, Middle, Last): William Anthony | | | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Flowers Anthony | | |
| 19a. INFORMANT'S NAME (Type/Print): Hazel Phillips Anthony | | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box CL 1, Preston, Md. 21655 | | | | |
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Eastern Shore Vet. Cem. | | | 20c. LOCATION — City or Town, State: Beulah, Maryland | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J Eskow | | | 22. NAME AND ADDRESS OF FACILITY: Federalsburg, Md. Framptom-Hawkins-Eskow, P.A. Funl.Home | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. CARCINOMA PROSTATE | 1 YEAR |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 [ ] YES 2 [ ] NO | 1 [ ] YES 2 [ ] NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 [ ] YES 2 [X] NO | HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | | M | 1 [ ] YES 2 [ ] NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| C. W. Frame MD | D00250 | ▶ 9/26/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 02 '89 | Gisha Davidson-Randall |

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29988

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): MERVIN TRIBBITT | | 2. DATE OF DEATH (Month, Day, Year): Sept. 22, 1989 | 3. TIME OF DEATH: 2:10 PM |
| 4. SOCIAL SECURITY NUMBER: 214-18-4956 | 5. SEX: 1 [X] M 2 [ ] F | 6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 12 9 1922 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |

| | | |
|---|---|---|
| 9a. FACILITY NAME (If not institution, give street and number): Ridgely-Greensboro Road | 9b. CITY, TOWN OR LOCATION OF DEATH: Ridgely | 9c. COUNTY OF DEATH: Caroline |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Caroline | 10c. CITY, TOWN OR LOCATION: Ridgely | 10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO |
| 10e. STREET AND NUMBER: Ridgely-Greensboro Rd., Rt.1 Box 27B | 10f. ZIP CODE: 21660 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 th gr. | College (1-4 or 5+): none | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Maintenance & truck driver | 16b. KIND OF BUSINESS/INDUSTRY: Food production & Fertilizer |

| | |
|---|---|
| 17. FATHER'S NAME (First, Middle, Last): Acie Tribbitt | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Edith Tribbitt |
| 19a. INFORMANT'S NAME (Type/Print): Leona M. Tribbitt | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 27B, Ridgely, MD 21660 |

| | | |
|---|---|---|
| 20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ridgely Cemetery | 20c. LOCATION — City or Town, State: Ridgely, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randolph C. Moore | 22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Denton, Maryland 21629 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. LUNG CANCER | 1 YR |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO | 26. PLACE OF DEATH (Check only one). HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify) | |
| 27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Leyton B Carmean MD | 29c. LICENSE NUMBER: D 01225 | 29d. DATE SIGNED (Month, Day, Year): 9-26-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RT 3 BOX 106 EASTON MD 21601

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 02 89 | 32. REGISTRAR'S SIGNATURE: Linda Davidson-Randall |

DHMH-16 Rev 1/89

89 29989

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): JOSEPHINE VAUGHAN | | 2. DATE OF DEATH (Month, Day, Year): Sept. 27, 1989 | 3. TIME OF DEATH: 4:00 P M |
| 4. SOCIAL SECURITY NUMBER: 215-34-7361 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 89 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.) | 7. DATE OF BIRTH (Month, Day, Year): 8 27 1900 |
| 8. BIRTHPLACE (State or Foreign Country): Virginia | | | |
| 9a. FACILITY NAME (If not institution, give street and number): Wesleyan Health Care Center | 9b. CITY, TOWN OR LOCATION OF DEATH: Denton | 9c. COUNTY OF DEATH: Caroline | |

RESIDENCE OF DECEDENT

| | | | |
|---|---|---|---|
| 10a. STATE: Maryland | 10b. COUNTY: Talbot | 10c. CITY, TOWN OR LOCATION: Easton | 10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 205 Brookwood Avenue | 10f. ZIP CODE: 21601 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: Caucasian |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 gr. College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher | 16b. KIND OF BUSINESS/INDUSTRY: Education | |
| 17. FATHER'S NAME (First, Middle, Last): Patrick Henry McNulty | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Rebecca Clark | | |
| 19a. INFORMANT'S NAME (Type/Print): Mary Vaughan | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 205 Brookwood Avenue, Easton, MD 21601 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Bruffey's Creek Cemetery | 20c. LOCATION — City or Town, State: West Hillsboro, Virginia | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph Moore | 22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Denton, Maryland 21629 | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Myocardial Infarction | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Insufficeny, Denserative Joint Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Rob Lappin

29c. LICENSE NUMBER: D33294

29d. DATE SIGNED (Month, Day, Year): ▶ 9/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rob Lappin MD PO Box 122 Goldsboro, Md. 21636

31. DATE FILED (Month, Day, Year): OCT 02 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29990

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): WILLIAM ANDREW | | | 2. DATE OF DEATH (Month, Day, Year): 10 9 89 | 3. TIME OF DEATH: 1825 PM |
| 4. SOCIAL SECURITY NUMBER: 040-10-1366 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 71 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.) | 7. DATE OF BIRTH (Month, Day, Year): NOV. 18, 1917 | 8. BIRTHPLACE (State or Foreign Country): MAINE |
| 9a. FACILITY NAME (If not institution, give street and number): 5000 KLEE MILL Rd | | 9b. CITY, TOWN OR LOCATION OF DEATH: SYKESVILLE | | 9c. COUNTY OF DEATH: CARROLL |
| **RESIDENCE OF DECEDENT** | | | | |
| 10a. STATE: MD | 10b. COUNTY: CARROLL | 10c. CITY, TOWN OR LOCATION: SYKESVILLE | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5000 KLEE MILL Rd | | 10f. ZIP CODE: 21784 | | 10g. CITIZEN OF WHAT COUNTRY? USA |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): College + 3yrs | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SELF EMPLOY | 16b. KIND OF BUSINESS/INDUSTRY: PASTORAL COUNCILOR | | |
| 17. FATHER'S NAME (First, Middle, Last): LAURENCE C. ANDREW | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN RICHARDSON | | |
| 19a. INFORMANT'S NAME (Type/Print): ELAINE E. ANDREW | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5000 KLEE MILL RD. SYKESVILLE, MD. 21784 | | | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CARROLL CREMATION | 20c. LOCATION — City or Town, State: HAMPSTEAD MD | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight | 22. NAME AND ADDRESS OF FACILITY: HAIGHT F.H. Box 195 Sykesville, MD. 21784 | | | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC CANCER OF THE PROSTATE — 30 MOS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☐ NO |

| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLACE OF DEATH (Check only one) | |
|---|---|---|
| 1 ☐ YES 2 ☒ NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|---|
| 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | | M | 1 ☐ YES 2 ☐ NO | |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Carlos E. Fernandez | D01079 | ▶ 10/10/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 13 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29991

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jerry R Buchanan | | | 2. DATE OF DEATH (Month, Day, Year): 9 29 1989 | 3. TIME OF DEATH: 2:13 P M |
| 4. SOCIAL SECURITY NUMBER: 332-34-4192 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 47 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 9/23/1942 | 8. BIRTHPLACE (State or Foreign Country): Kentucky |
| 9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hosp | | 9b. CITY, TOWN OR LOCATION OF DEATH: Westminster | 9c. COUNTY OF DEATH: Carroll | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Indiana | 10b. COUNTY: Putnam | 10c. CITY, TOWN OR LOCATION: Cloverdale | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: Rural Rt. 2, Box 218-78 | | 10f. ZIP CODE: 46120 | 10g. CITIZEN OF WHAT COUNTRY?: U.S. |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: ?? | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ? College (1-4 or 6+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver | 16b. KIND OF BUSINESS/INDUSTRY: Transportation | |
| 17. FATHER'S NAME (First, Middle, Last): Jessie Buchanan | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Louise Walker | |
| 19a. INFORMANT'S NAME (Type/Print): Patricia Buchanan | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2, Box 218-78, Cloverdale, Indiana 46120 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Boggstown Cemetery | 20c. LOCATION — City or Town, State: Boggstown, Indiana | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr. | | 22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Atherosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| | 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO |

| | | |
|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: Juan A. Suriel MD | 29c. LICENSE NUMBER: D23023 | 29d. DATE SIGNED (Month, Day, Year) ▶ 9-29-89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JUAN A. SURIEL, M.D. CARROLL CO. GEN. HOSP. WESTMINSTER MD.

| | |
|---|---|
| 31. DATE FILED (Month, Day, Year): OCT 4 '89 | 32. REGISTRAR'S SIGNATURE: Juanita Watson-Randall |

DHMH-16 Rev 1/89

IEEES 89

89 29992

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Albert Thomas Cantow
2. DATE OF DEATH (Month, Day, Year): 10 - 18 - 89
3. TIME OF DEATH: 10:00 EST PM
4. SOCIAL SECURITY NUMBER: 217-30-2990
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 53 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)
7. DATE OF BIRTH (Month, Day, Year): 12-14-35
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 2104 Country Fair Lane
9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville
9c. COUNTY OF DEATH: Carroll County

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Carroll County
10c. CITY, TOWN OR LOCATION: Sykesville
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2104 Country Fair Lane
10f. ZIP CODE: 21784
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Rep.
16b. KIND OF BUSINESS/INDUSTRY: Financial Services Co.
17. FATHER'S NAME (First, Middle, Last): Albert Henry Cantow
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Catherine Hart
19a. INFORMANT'S NAME (Type/Print): Concetta M. Cantow
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2104 Country Fair Lane Sykesville, MD 21784
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lake View Memorial Park
20c. LOCATION — City or Town, State: Sykesville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian K. Haight
22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. BOX 195) Sykesville, MD 21784 (301)-795-1400

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic (11) hypernephroma — one year

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes melleitus

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [✓] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: G.G. Schlenoff Jr. MD
29c. LICENSE NUMBER: D22557
29d. DATE SIGNED (Month, Day, Year): ▶ 10/19/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): E.G. Schlenoff 1247 Liberty Rd Eldersburg Md 21784
31. DATE FILED (Month, Day, Year): OCT 20 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit-permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 29993

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

**1. DECEDENT'S NAME** (First, Middle, Last): Mary Agnes GAMber

**2. DATE OF DEATH** (Month, Day, Year): Oct. 13, 1988

**3. TIME OF DEATH**: 10:00 AM

**4. SOCIAL SECURITY NUMBER**: 219 74 4408

**5. SEX**: 1 ☐ M 2 ☒ F

**6. AGE** (In yrs. last birthday): 84 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

**7. DATE OF BIRTH** (Month, Day, Year): Oct. 2, 1905

**8. BIRTHPLACE** (State or Foreign Country): Md.

**9a. FACILITY NAME** (If not institution, give street and number): 1331 BALTO. BLVD

**9b. CITY, TOWN OR LOCATION OF DEATH**: WESTMINSTER

**9c. COUNTY OF DEATH**: CARROLL

**RESIDENCE OF DECEDENT**

**10a. STATE**: MD.

**10b. COUNTY**: CARROLL

**10c. CITY, TOWN OR LOCATION**: WESTMINSTER

**10d. INSIDE CITY LIMITS?** 1 ☐ YES 2 ☒ NO

**10e. STREET AND NUMBER**: 1331 BALTO. BLVD

**10f. ZIP CODE**: 21157

**10g. CITIZEN OF WHAT COUNTRY?**: USA

**11. MARITAL STATUS**: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

**12. WAS DECEDENT EVER IN U.S. ARMED FORCES?** 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

**13. WAS DECENDENT OF HISPANIC ORIGIN?** (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

**14. RACE — American Indian, Black, White, etc.** Specify: WHITE

**15. DECEDENT'S EDUCATION** (Specify only highest grade completed)
Elementary/Secondary (0-12): GRADE SCHOOL
College (1-4 or 5+):

**16a. DECEDENT'S USUAL OCCUPATION** (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE

**16b. KIND OF BUSINESS/INDUSTRY**:

**17. FATHER'S NAME** (First, Middle, Last): THOMAS WALTER SEWARD

**18. MOTHER'S NAME** (First, Middle, Maiden Surname): JANE E. BAUBLITZ

**19a. INFORMANT'S NAME** (Type/Print): MARGARET GAMBER

**19b. MAILING ADDRESS** (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1331 BALTO. BLVD. WESTMINSTER, MD. 21157

**20a. METHOD OF DISPOSITION**: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

**20b. PLACE OF DISPOSITION** (Name of cemetery, crematory or other place): GARDEN FOREST VET CEMETERY

**20c. LOCATION — City or Town, State**: OWINGS MILL, MD 21184

**21. SIGNATURE OF FUNERAL SERVICE LICENSEE**: ▶ Harry W. Haight

**22. NAME AND ADDRESS OF FACILITY**: Haight F.H. Box 195 Sykesville, MD.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

**23. PART I.** Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CARDIO RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. CHF

DUE TO (OR AS A CONSEQUENCE OF):

c. COPD -

DUE TO (OR AS A CONSEQUENCE OF):

d. CACHESIA

**PART II.** Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**24a. WAS AN AUTOPSY PERFORMED?** 1 ☐ YES 2 ☐ NO

**24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?** 1 ☐ YES 2 ☐ NO

**25. WAS CASE REFERRED TO MEDICAL EXAMINER?** 1 ☐ YES 2 ☒ NO

**26. PLACE OF DEATH** (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

**27. MANNER OF DEATH**: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

**28a. DATE OF INJURY** (Month, Day, Year)

**28b. TIME OF INJURY** M

**28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO

**28d. DESCRIBE HOW INJURY OCCURED**

**28e. PLACE OF INJURY** — At home, farm, street, factory, office building, etc. (Specify)

**28f. LOCATION** (Street and Number or Rural Route Number, City or Town, State)

**29a. CERTIFIER** (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

**29b. SIGNATURE AND TITLE OF CERTIFIER**: [signature] MD PHYSICIAN

**29c. LICENSE NUMBER**: D25804

**29d. DATE SIGNED** (Month, Day, Year): ▶ 10/15/89

**30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27)** (Type, Print)

**31. DATE FILED** (Month, Day, Year): OCT 18 89

**32. REGISTRAR'S SIGNATURE**: Julia Davidson-Randall

DHMH-16 Rev 1/89

Item:11 per Health Dept. G-657
11-3-89 cm

89 29994

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN P. HURLEY
2. DATE OF DEATH (Month, Day, Year): 10 15 89
3. TIME OF DEATH: 12:10 M
4. SOCIAL SECURITY NUMBER: 023-20-5907
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 11/24/1925
8. BIRTHPLACE (State or Foreign Country): MASS
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster, MD 21157
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: CARROLL
10c. CITY, TOWN OR LOCATION: WESTMINSTER
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 450 ROBINS WAYS
10f. ZIP CODE: 21157
10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WWII
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 4 YEARS
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DIRECTOR
16b. KIND OF BUSINESS/INDUSTRY: SSA

17. FATHER'S NAME (First, Middle, Last): JAMES A. HURLEY
18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHERINE MARIE MULLANEY
19a. INFORMANT'S NAME (Type/Print): MICHAEL D. HURLEY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 63095 S. OLD WASHINGTON RD. ELDERSBURG MD. 21784
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LAKEVIEW GARDEN
20c. LOCATION — City or Town, State: SYKESVILLE MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight
22. NAME AND ADDRESS OF FACILITY: HAIGHT F.H. Box 195 SYKESVILLE MD 21784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOGENIC SHOCK
DUE TO (OR AS A CONSEQUENCE OF):
b. ACUTE M.I.
DUE TO (OR AS A CONSEQUENCE OF):
c. C.A.D.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
PNEUMONIA (2)

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D18099
29d. DATE SIGNED (Month, Day, Year): ▶ 10-16-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 611 Nursery Rd. Westminster, Md. 21157
31. DATE FILED (Month, Day, Year): OCT 18 '89
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

89 29995

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): June Elgen Lippy
2. DATE OF DEATH — MONTH: 10 DAY: 19 YEAR: 89
3. TIME OF DEATH: 5:48 A M
4. SOCIAL SECURITY NUMBER: 219 14 7740
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/30/21
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Westminster
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 48 Pennsylvania Avenue
10f. ZIP CODE: 21157
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: High School
17. FATHER'S NAME (First, Middle, Last): William Elgen Lippy
18. MOTHER'S NAME (First, Middle, Maiden Surname): Marian Rebecca Fritz
19a. INFORMANT'S NAME (Type/Print): M. Jean Cook
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3860 Sells Mill Rd, Taneytown, MD 21787
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Crematory
20c. LOCATION — City or Town, State: Hampstead, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Myers
22. NAME AND ADDRESS OF FACILITY: Myers Funeral Home, 91 Willis St, Westminster, MD

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Aspirin Overdose
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 10/18/89
28b. TIME OF INJURY: 9 P M
26c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED: Subject ingested aspirin
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 48 Penn Ave., Westminster
29a. CERTIFIER (Check only one) — 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin, M.D. - Assistant
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 10/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D. - Assistant 111 Penn St. Balto.MD
31. DATE FILED (Month, Day, Year): OCT 24 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 29996

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Lawrence Edward Martin | | | 2. DATE OF DEATH (Month, Day, Year): 10 - 21 - 89 | 3. TIME OF DEATH: 1225 PM |
| 4. SOCIAL SECURITY NUMBER: 217-36-4479 | 5. SEX: 1 ☒ M 2 ☐ F | 6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.) | 7. DATE OF BIRTH (Month, Day, Year): 1-20-14 | 8. BIRTHPLACE (State or Foreign Country): MD |
| 9a. FACILITY NAME (If not institution, give street and number): Sykesville Elder Care | | 9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville | | 9c. COUNTY OF DEATH: Carroll |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Hampstead | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 4395 Utz Road | | 10f. ZIP CODE: 21074 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+): | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer | 16b. KIND OF BUSINESS/INDUSTRY: Farming | |
| 17. FATHER'S NAME (First, Middle, Last): Walter E. Martin | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Hare | |
| 19a. INFORMANT'S NAME (Type/Print): Ethel E. Martin | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4395 Utz Rd., Hampstead, Md. 21074 | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Mem. Gardens | 20c. LOCATION — City or Town, State: Finksburg, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. F. Eckhardt | | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 3296 Charmil Dr., Manchester, Md. 21102 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Pulmonary insufficiency | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Bronchial carcinoma | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☐ NO | 1 ☐ YES 2 ☐ NO |

| | | | | |
|---|---|---|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) | | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Jose L. Chapulle MD | | ▶ 10/21/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jose L. Chapulle, M.D., 6342 Barnett Ave. SYKESVILLE

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 23 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29997

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Edna Nine | | | 2. DATE OF DEATH (Month, Day, Year): 10-05-89 | 3. TIME OF DEATH: 3:35 P M |
| 4. SOCIAL SECURITY NUMBER: 213-48-3016 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): 03-22-11 | 8. BIRTHPLACE (State or Foreign Country): Maryland |
| 9a. FACILITY NAME (If not institution, give street and number): Springfield Hospital Center | | 9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville, Maryland | | 9c. COUNTY OF DEATH: Carroll |
| RESIDENCE OF DECEDENT | | | | |
| 10a. STATE: Maryland | 10b. COUNTY: Baltimore | 10c. CITY, TOWN OR LOCATION: Baltimore | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 6102 Falls Road, Baltimore, Maryland | | 10f. ZIP CODE: 21209 | | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. |
| 11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | | 14. RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+) | | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): None | | 16b. KIND OF BUSINESS/INDUSTRY: — |
| 17. FATHER'S NAME (First, Middle, Last): John Nine | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabel Disnberg | | |
| 19a. INFORMANT'S NAME (Type/Print): Medical Records, Springfield Hospital | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Sykesville, Maryland 21784 | | |
| 20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Center | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Springfield Cemetery | | 20c. LOCATION — City or Town, State: Sykesville, Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brian L. Haight | | 22. NAME AND ADDRESS OF FACILITY: HAIGHT FUNERAL HOME (P.O. Box 195) SYKESVILLE, MD 21784 (301)-795-1400 | | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. Congestive heart failure | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. Pneumonia | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe kyphosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

| 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
|---|---|---|---|
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| Shakera Khan. MD | D36291 | ▶ 10/5/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Shakera Khan, M.D., Springfield Hospital Center, Sykesville, Maryland 21784

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 13 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

89 29998

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | |
|---|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): ~~PAT~~ SYLVIA M PALMER | | | 2. DATE OF DEATH: MONTH 10 DAY 17 YEAR 89 | 3. TIME OF DEATH: 0900 M |
| 4. SOCIAL SECURITY NUMBER: 217-10-9711-D | 5. SEX: 1 ☐ M 2 ☑ F | 6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): JULY 23, 1924 | 8. BIRTHPLACE (State or Foreign Country): PA |
| 9a. FACILITY NAME (If not institution, give street and number): 120 DUNROVIN RD. | | 9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER | | 9c. COUNTY OF DEATH: CARROLL |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: MD | 10b. COUNTY: CARROLL | 10c. CITY, TOWN OR LOCATION: WESTMINSTER | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| 10e. STREET AND NUMBER: 120 DUNROVIN RD. | 10f. ZIP CODE: 21157 | 10g. CITIZEN OF WHAT COUNTRY?: USA | |

| | | | |
|---|---|---|---|
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+) | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SEAMSTRESS | 16b. KIND OF BUSINESS/INDUSTRY: FACTORY SEWING | |
| 17. FATHER'S NAME (First, Middle, Last): CHARLES G. DONALDSON | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE BOOZEL | |
| 19a. INFORMANT'S NAME (Type/Print): GRADY CARTER | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD#2 THOMASVILLE, PA 17364 | | |
| 20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify) | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MEADOW BRANCH CEM | 20c. LOCATION — City or Town, State: WESTMINSTER MD | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] | 22. NAME AND ADDRESS OF FACILITY: LITTLES F.H. 34 MADLEAN | LITTLESTOWN PA 17340 | |

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

| | | Approximate Interval Between Onset and Death |
|---|---|---|
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → | a. ADENOCARCINOMA OF BREAST - METASTATIC | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | c. | |
| | DUE TO (OR AS A CONSEQUENCE OF): | |
| | d. | |

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|---|---|
| 1 ☐ YES 2 ☒ NO | 1 ☐ YES 2 ☒ NO |

| | |
|---|---|
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify) |

| | | | | |
|---|---|---|---|---|
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year): N/A | 28b. TIME OF INJURY: M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one):
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---|---|
| THOMAS K. GALVIN III MD | D31660 | ▶ 10/17/89 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): THOMAS K. GALVIN MD 542 WASHINGTON RD WESTMINSTER MD 21157

| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE |
|---|---|
| OCT 23 '89 | Julia Davidson-Randall |

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

## TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH B. SENSENEY
2. DATE OF DEATH (Month, Day, Year): 10 11 89
3. TIME OF DEATH: 0910A M
4. SOCIAL SECURITY NUMBER: 220-36-9643
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 05-14-1906
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Carroll County Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Westminster
9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Carroll
10c. CITY, TOWN OR LOCATION: Westminster
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 927 Gorsuch RD
10f. ZIP CODE: 21157
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5 +)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher
16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Charles Baltzell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Drake
19a. INFORMANT'S NAME (Type/Print): Wes Senseney
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 927 Gorsuch Rd., Westminster, Md. 21 157
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pleasant Valley
20c. LOCATION — City or Town, State: Westminster, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert K Pritts Sr/wl — Robert K. Pritts, Sr.
22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home, 412 Washington Rd., Westminster, MD.

## TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 4 DAYS

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. ASPIRATION

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.: HYPERTENSION; CEREBROVASCULAR INSUFFICIENCY; ATRIAL FIBRILLATION / SICK SINUS SYNDROME

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul W Eggermeade
29c. LICENSE NUMBER: D01079
29d. DATE SIGNED (Month, Day, Year): 10 11 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)
31. DATE FILED (Month, Day, Year): OCT 13 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

| | | | |
|---|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last): Jane Ellen Serravalle | | 2. DATE OF DEATH (Month, Day, Year): Oct. 14, 1989 | 3. TIME OF DEATH: 0720 4M |
| 4. SOCIAL SECURITY NUMBER: 214-14-8037 | 5. SEX: 1 ☐ M 2 ☒ F | 6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.) | 7. DATE OF BIRTH (Month, Day, Year): Sept. 12, 1918 |
| 8. BIRTHPLACE (State or Foreign Country): Maryland | | | |
| 9a. FACILITY NAME (If not institution, give street and number): 5010 Stoney Lane | 9b. CITY, TOWN OR LOCATION OF DEATH: Manchester | 9c. COUNTY OF DEATH: Carroll | |

**RESIDENCE OF DECEDENT**

| | | | |
|---|---|---|---|
| 10a. STATE: Md. | 10b. COUNTY: Carroll | 10c. CITY, TOWN OR LOCATION: Manchester | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO |
| 10e. STREET AND NUMBER: 5010 Stoney Lane | 10f. ZIP CODE: 21102 | 10g. CITIZEN OF WHAT COUNTRY?: U.S.A. | |
| 11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: | 14. RACE — American Indian, Black, White, etc. Specify: White |

| | | | |
|---|---|---|---|
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4 | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife | 16b. KIND OF BUSINESS/INDUSTRY: Homemaking |
| 17. FATHER'S NAME (First, Middle, Last): Harry Whitelock | | 18. MOTHER'S NAME (First, Middle, Maiden Surname): Elice | |
| 19a. INFORMANT'S NAME (Type/Print): Joseph Serravalle | | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5010 Stoney Lane, Manchester, Md. 21102 | |
| 20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory | 20c. LOCATION — City or Town, State: Baltimore, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. J. Eckhardt | | 22. NAME AND ADDRESS OF FACILITY: Eckhardt Funeral Chapel 21102, 3296 Charmil Dr., Manchester, Md. | |

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. CARDIOPULMONARY ARREST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CEREBROVASCULAR ACCIDENT
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

| | | |
|---|---|---|
| 24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO | 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify) | |
| 27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED |
| | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| | | |
|---|---|---|
| 29b. SIGNATURE AND TITLE OF CERTIFIER: James L. Forsberg MD | 29c. LICENSE NUMBER: D33561 | 29d. DATE SIGNED (Month, Day, Year): ▶ 10-16-89 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James L. Forsberg MD 908 Washington Rd. Westminster MD 21157 | | |
| 31. DATE FILED (Month, Day, Year): OCT 17 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall | |

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**